the Canadian Nurse

VOLUME 57 • NUMBER 11

MONTREAL

NOVEMBER, 1961

HIGHLIGHTS

MACLAGGAN — The Changing Face of Nursing

WILLIAMS — Occupational Health in Saskatchewan

WOODS — Occupational Health Nursing in Saskatchewan

HOBBS — Occupational Health in the Hospital

WALKER — Health Goes to Work

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Between Ourselves

Here we are on the second page after appearing on the fourth page for more than 15 years. This move came about when our editorial staff began to plan the new title page and table of contents you see opposite.

You will observe that below each article we have noted the information concerning the authors that has appeared at the bottom of the first left-hand column of each article heretofore. Instead of the biographical data, we debated whether we should transfer the few lines of summary that appear above each article to the table of contents. We decided to leave those subheadings where you have become accustomed to finding them.

With the new format for the table of contents occupying two pages, we decided to shift the index to advertisers to the second last page of each issue. We have expanded this index to include all of the advertised educational opportunities, the large display advertisements featuring employment opportunities, and the various divisions of the classified advertising. We are confident that you will appreciate being able to locate these newly listed items more readily.

Recently, a subscriber wrote us expressing her appreciation of our recent innovations. Said she "What next?" Well, these are the latest changes. Who knows? There may be others almost any month. Keep an eye on this column for we will tell you about other developments as they materialize.

* * *

Those of you who have had an opportunity to read Saint-Exupery's *The Little Prince*, will be especially interested to follow KATHERINE MACLAGGAN'S interesting use of phrases from her chosen excerpt to focus her remarks on the changing face of nursing. Miss MacLaggan delivered this address at the convention of the Maritime Hospital Association last June.

* * *

When JEAN DORGAN, nurse turned social worker, was named to represent the Ottawa Study Group, and thus Canada, at the London, England meeting sponsored by the World Federation of Mental Health she says she "developed some appreciation of Cinderella's feelings when the Fairy Godmother told her she was going to the ball."

Under the chairmanship of Dr. KENNETH SODDY, scientific director of the World Federation, the representatives from study groups in Canada, Finland, France, Italy, Scotland, Spain, Switzerland, the United States and West Germany spent four days discussing the development of their groups, approaches to the study, problems and achievements. Miss ELIZABETH BARNES was coordinator of the study groups. The discussions were in English and French, with simultaneous translation provided. Their findings will re-inforce many of your own impressions of the psychological problems you encounter daily.

* * *

One seldom associates occupational health nursing with the province of Saskatchewan. The heavily industrialized areas of Canada — yes; but the most prairie-like of the western provinces — no! It will be of interest to you, therefore, to read of the work that is being done and to realize that the papers presented in this issue were given at a conference of occupational health workers in that province.

* * *

Recently, we received a telephone call from an advertiser who was much annoyed to suddenly discover that some yearbooks published by Canadian schools of nursing bore the imprint "Lithographed in U.S.A." As a loyal supporter of these student yearbooks for many years, our complainant asked "With so many lithographers in Canada looking for work, who do those girls use an American firm?" We did not know the answer to that question so we asked some of the Montreal schools of nursing whose yearbooks bore the telltale imprint.

It seems that the whole process is quite involved. On the one hand, there is a group of eager student nurses who have had little or no experience in preparing any kind of printed matter. On the other hand is the problem of finding a Canadian lithographer equipped to produce the desired yearbook at a price that is within the budget of the students. The American firm, it seems, concentrates on this type of work.

Happily for the schools of nursing that would like to "buy Canadian" we have learned that a publishing firm in Winnipeg is prepared to offer the same kind of assistance to the students at a comparable price. We have the literature from this company on hand and will gladly forward the name and address to schools of nursing requesting it.

THE CANADIAN NURSE

VOLUME 57 NUMBER 11

NOVEMBER 1961

1023 THE CHANGING FACE OF NURSING.....*K. MacLaggan*

Miss MacLaggan is third vice-president of the Canadian Nurses' Association and director of the School of Nursing, University of New Brunswick, Fredericton.

1027 OCCUPATIONAL HEALTH IN SASKATCHEWAN.....*N. Williams*

Dr. Williams is director of the Occupational Health Branch, Saskatchewan Department of Public Health, Regina.

1029 OCCUPATIONAL HEALTH NURSING IN SASKATCHEWAN.....*J. Woods*

Mrs. Woods is consultant with the Occupational Health Branch of the Saskatchewan Department of Public Health.

1032 OCCUPATIONAL HEALTH IN THE HOSPITAL.....*H. Hobbs*

Miss Hobbs is Health Services Coordinator of the student and employee health service, University Hospital, Saskatoon.

1036 HEALTH GOES TO WORK.....*M. I. Walker*

Miss Walker is senior nursing consultant, Division of Occupational Health, Department of National Health and Welfare, Ottawa.

1040 PSYCHOLOGICAL PROBLEMS IN GENERAL HOSPITAL.....*J. Dorgan*

Miss Dorgan, who is consultant in social work, Mental Health Division of the Department of National Health and Welfare, represented the Ottawa Group at an international gathering in London, England.

1048 CARDIAC ARREST.....*L. M. Hampson and S. V. Temple*

Dr. Hampson is chief of the department of Anesthesiology and Mrs. Temple is clinical instructor in the operating room at the Civic Hospital, Ottawa, Ontario.

1051 ADMINISTRATION AND THE CHANGING ROLE OF THE NURSE *C. A. Meilicke*

Mr. Meilicke is supervisor of the correspondence course in hospital administration in connection with the University of Saskatchewan, Saskatoon.

1056 PROFESSIONAL NURSES' ASSOCIATIONS AND GOOD PUBLIC RELATIONS.....*M. E. Kerr*

1061 THE HOSPITAL BED.....*M. Langlois*

Dr. Langlois is medical director of Hotel Dieu d'Alma, Quebec. This address was given at a meeting of nurses of district No. 10, ANPQ.

1064 PROVINCE-WIDE BARGAINING FOR NURSES.....*E. V. Hood*

Miss Hood is Director of Personnel Services for the Registered Nurses' Association of British Columbia.

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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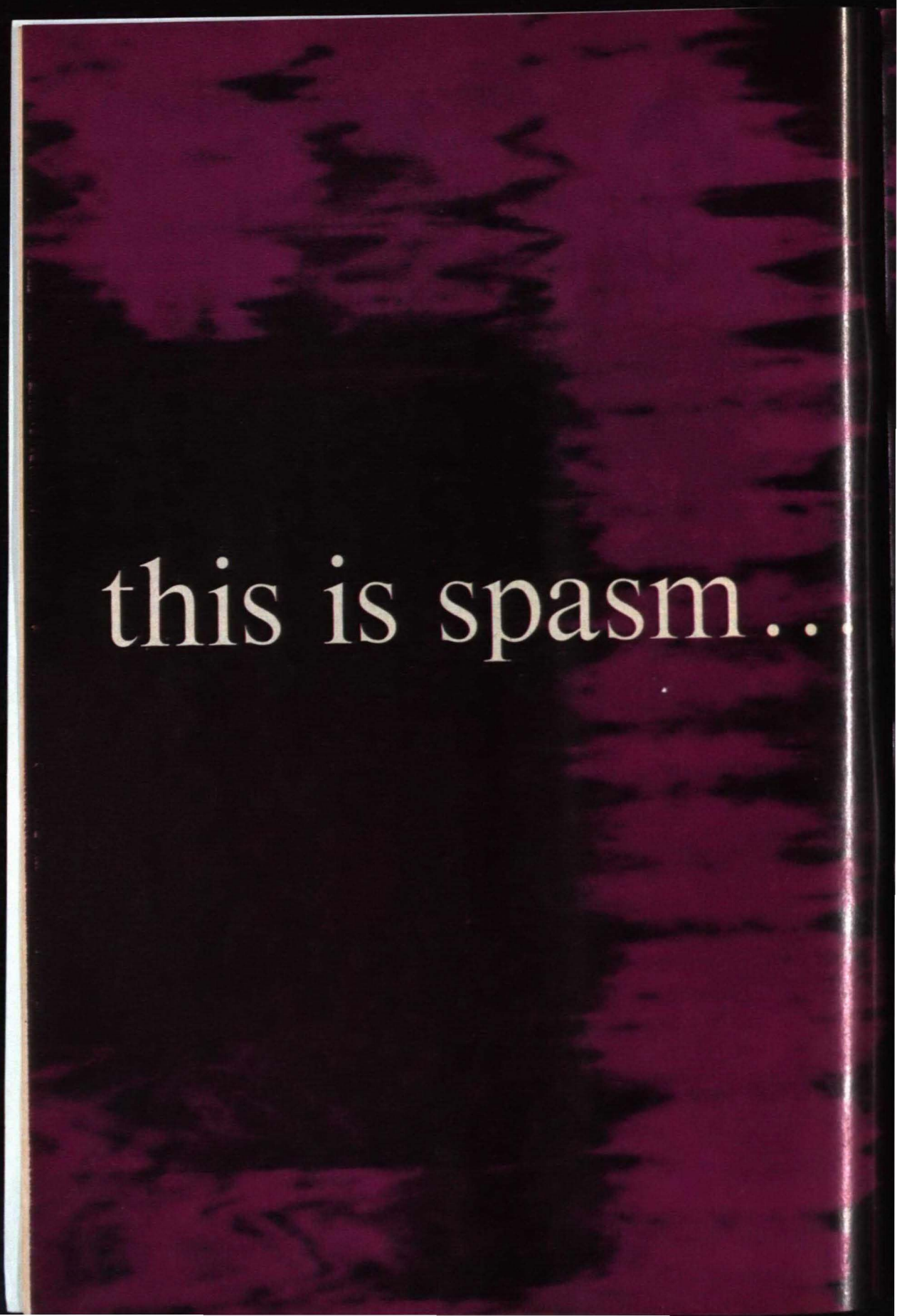
covers all areas of planning, directing, supervising, and evaluating the work of the nursing team

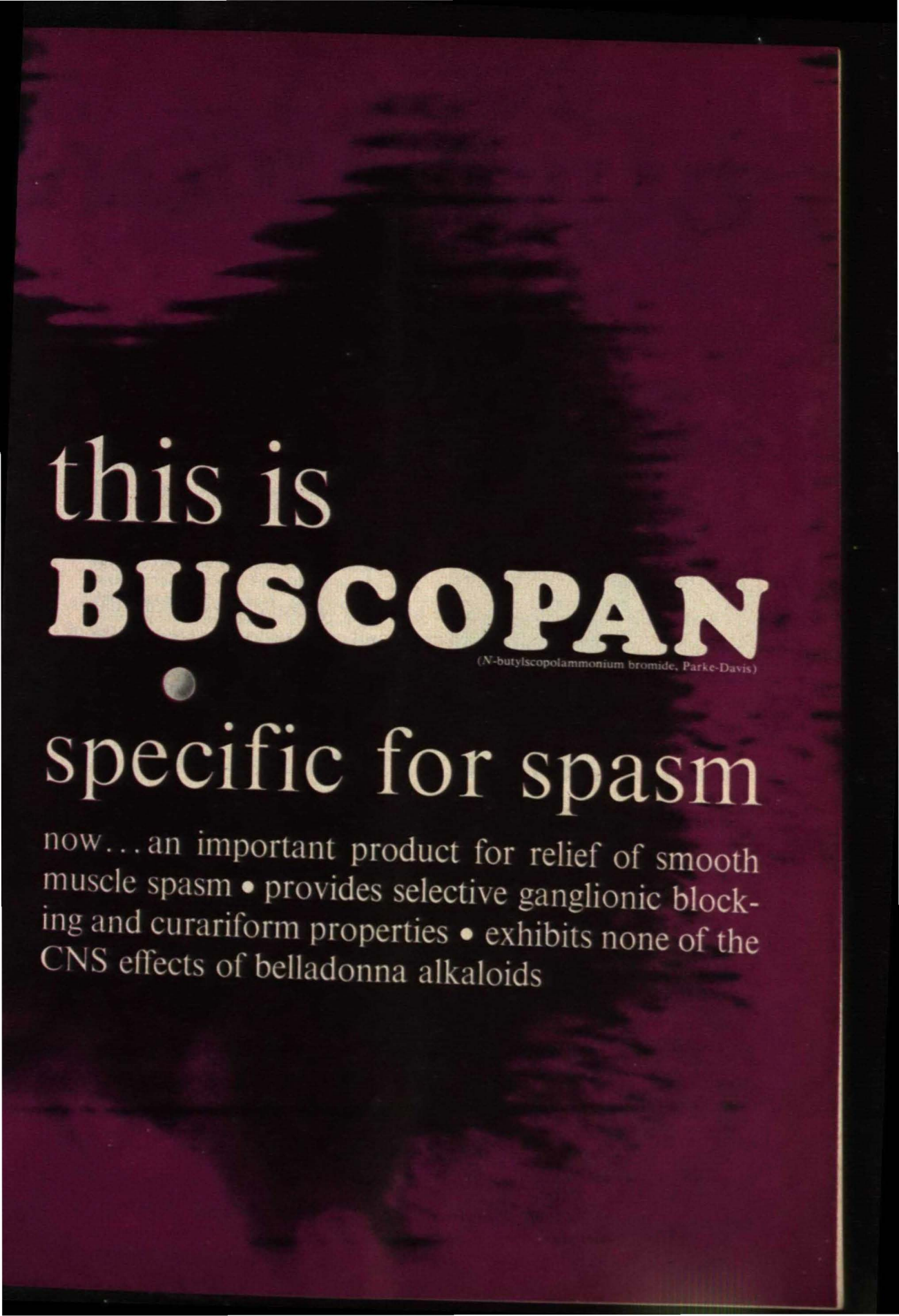
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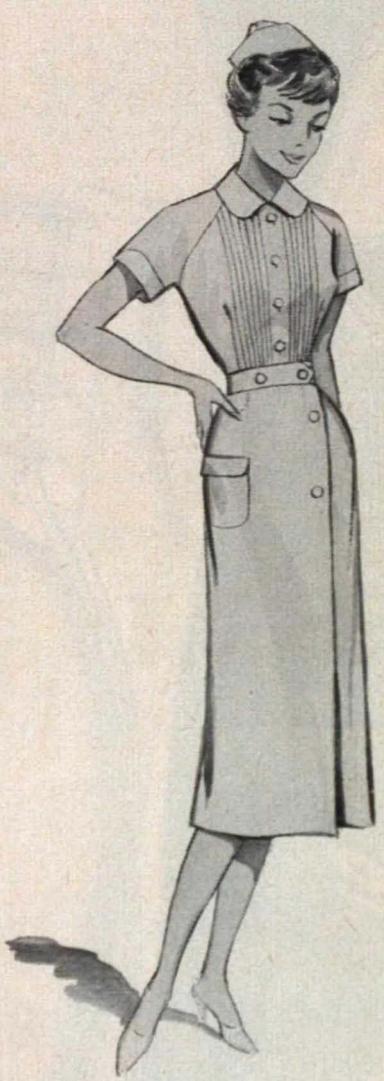

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Random Comments

Dear Editor:

A group of Toronto General Hospital nurses have been meeting to discuss the question of low-cost, cooperative living for retired nurses with limited means. We have discussed small apartments with a common dining room and rooms for social life, since some nurses are beyond housekeeping and prefer rooms with board.

I wonder if any of the *Journal's* subscribers have any information on what has been done or is being done in this field across Canada. We have heard of some research along this line for selected groups such as teachers, etc. done by the Department of Commerce and Development on a cooperative or community basis. We have also heard of much progress and some attractive solutions for cooperative living in the United States.

Many retired nurses are now faced with rents beyond their means, and also isolation from friends with mutual interests. It would seem a happy solution, for those unable to keep up contacts, to be brought together for mutual benefits.

I will be grateful for information that readers may be able to send me.

(Mrs.) A. B. Gordon,
494 Avenue Rd., Apt. 69,
Toronto, Ontario.

Dear Editor:

Thank you kindly for sending the reference list that accompanies Mrs. Peitchinis' article "Psychological Needs." It will be most helpful to our instructors, I am sure.

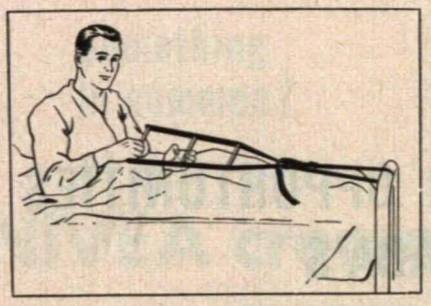
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Mabel Brown, Librarian,
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The Toronto Western Hospital, Ontario.

Dear Editor:

I glanced through the latest edition of the *Journal* and was both startled and pleased to see Martha Gibson's letter.

I quite agree with her that nursing per se has not changed, nor has the role of the nurse except in the light of changing con-



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cepts of treatment; but the meaning of nursing has been garbled beyond reason by the efforts of some individuals who seem to feel that our "changing world" demands a constant re-interpretation of the "real meaning of nursing." Consequently, the nurse today suffers from a constant barrage of words — each author trying to express her ideas as if they were both new and unthought of heretofore. The terminology also changes every few years and, in accordance with the author's educational acquirements, becomes more obscure each time.

If one were to try to read the number of journals, magazines and pamphlets, not to mention the larger publications printed, presumably relative to her work, she would have no time for anything else. And in searching through this morass of literature for some reference to help in solving her problems, too often she is confronted with pages of statistics showing some involved study the results of which appear to benefit no one, articles giving myriad details of the author's opinions regarding someone's theory, or worst of all, another treatise on the "theme of the day" namely "Where is Nursing Going?" or its many variants, "What is the Nurse?" etc. The confusion created by this endless verbiage leaves the younger nurses bewildered and the older ones unresponsive and disinterested.

It is high time reason, common sense and understandable English came back to nursing, with less being said and more being done. FERNE TROUT, British Columbia.

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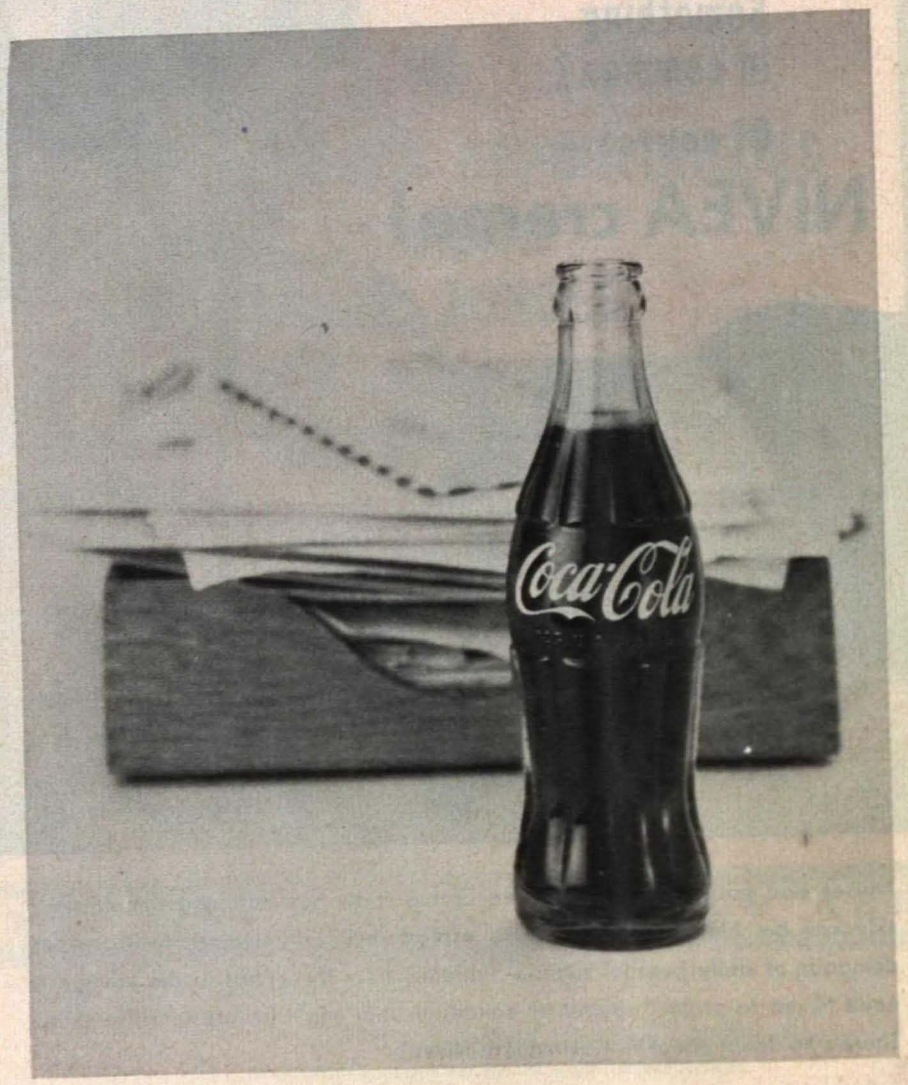
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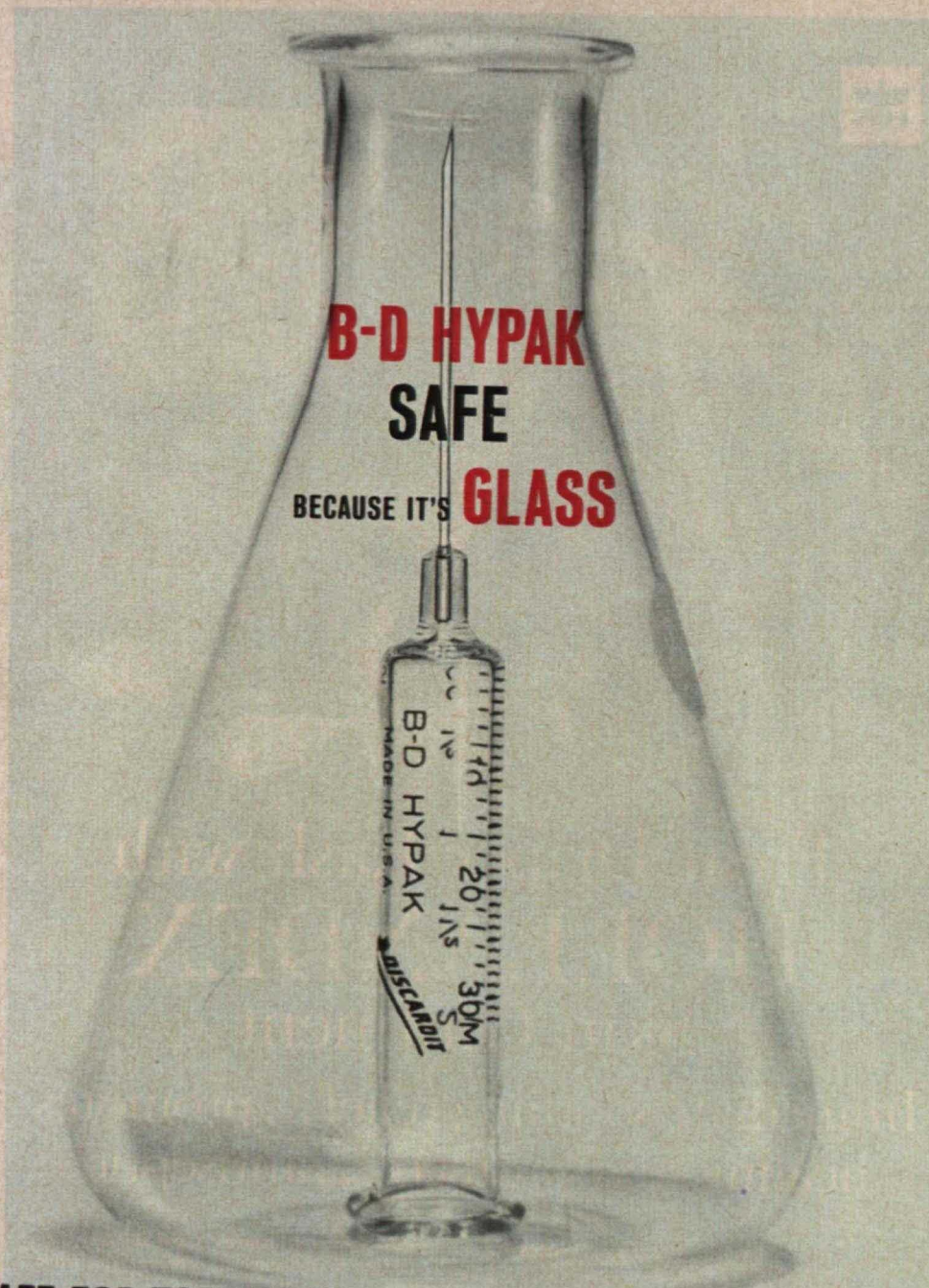
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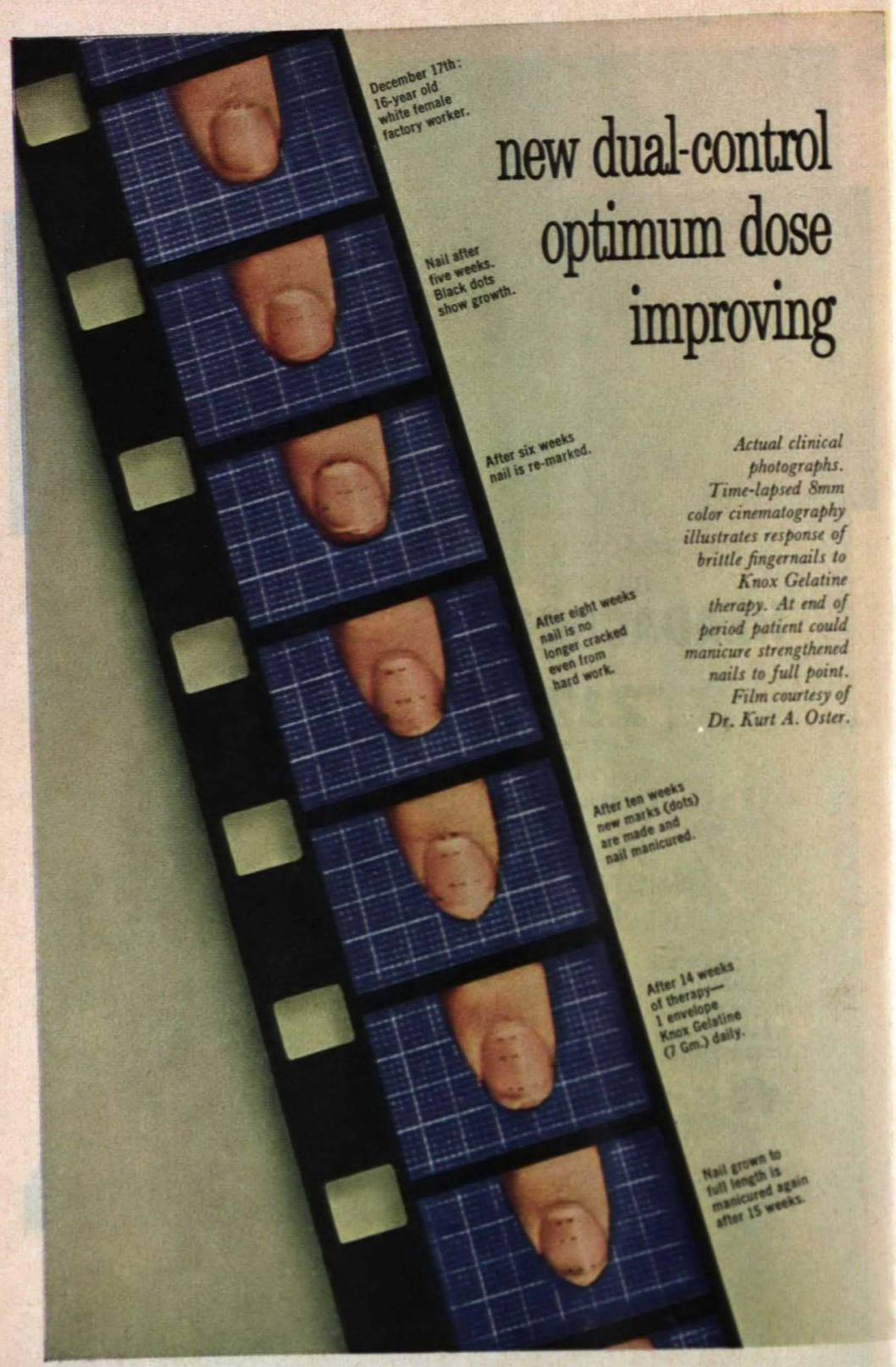
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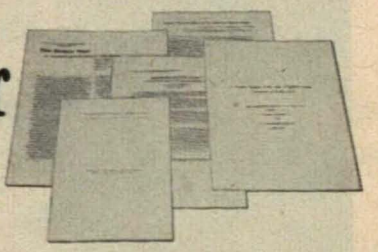




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Actual clinical photographs. Time-lapsed 8mm color cinematography illustrates response of brittle fingernails to Knox Gelatine therapy. At end of period patient could manicure strengthened nails to full point. Film courtesy of Dr. Kurt A. Oster.

study[1] establishes of Knox Gelatine for brittle fingernails



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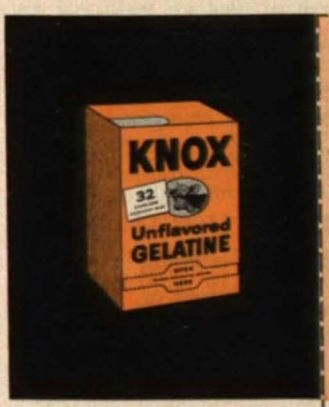
the results of this investigation show:

a. *Adequate intake of Knox Gelatine (one envelope or seven grams once a day) improved 77 per cent of patients in the spring group and 91 per cent of patients in the winter group.*

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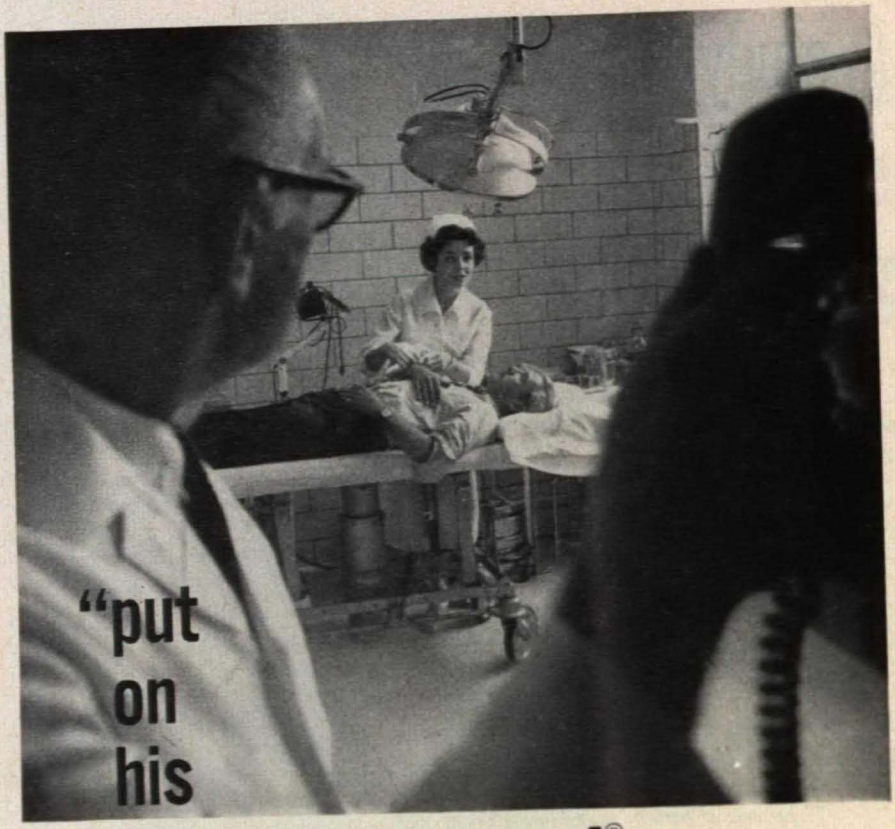


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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

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MONTREAL, NOVEMBER 1961

The Changing Face of Nursing

NURSING IS A NEEDLE with a great long thread, piercing and holding together the sum of the hospital fabric. To complete this image of our role, one has only to keep in mind that the needle is given direction by the head and heart of nursing, which are, in turn, susceptible to the pressures of a given time and place. So it is that the destiny of nursing and the destiny of the hospital are inexorably bound together.

Do you hold the belief that the interest of nursing can gain and hold advantage only at the price of disadvantage to the interests of the hospital? Not so long as we are both motivated by the ideal of service to the patient and to the community; not so long as nursing and the hospital remember that one is dependent upon the other; not so long as we recognize that "the duty to give and the opportunity to receive help arise frequently for both of us;"[1] not so long as we remember, in the presence of a difficulty, to take corrective action through communication.

So that we may arrive quickly to that point of shared perceptions and shared meaning — the essence of communication — let me paraphrase



KATHERINE MACLAGGAN

a section from *The Little Prince.*[2]

The Little Prince said, "I have a common rose, and three volcanoes that come up to my knees — and one of them perhaps extinct forever . . . That doesn't make me a very great prince."

And he lay down in the grass and cried.

It was then that the fox appeared.

"Good morning," said the Fox.

"Good morning" the Little Prince responded politely. "Who are you? Come and play with me."

"I cannot play with you. I am a fox and I am not tamed."

"What does that mean — tame?" asked the Little Prince.

Said the Fox, "It means to be unique in all the world, to be needed, to establish ties, to be understood. One only understands the things that one tames."

"What must I do to tame you? asked the Little Prince.

The Fox said, "You must study me. You must learn all there is to know about me and my ways. You must be patient and constant and thoughtful. And you must spend time with me."

So the Little Prince tamed the wild fox, and when the hour of his departure drew near he came to say good-bye.

"Let me tell you this secret," said the Fox who was no longer wild, "you become responsible forever for what you have tamed."

So that he would never forget, the Little Prince repeated, "You become responsible forever for what you have tamed."

Unique in All the World

Is nursing unique in all the world? There are those who think it is not. There are those who think the nurse's *only* function is to carry out the therapeutic plan as initiated by the physician. Even if this were so, the World Health Organization reminded us in 1950: "In many countries where medicine is highly developed and nursing is not, the health status of the people does not reflect the advanced stage of medicine."

Heard around the nursing world is Virginia Henderson's voice, saying:

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health and its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. This aspect of her work, this part of her function, she initiates and controls; of this she is master.[3]

When this concept becomes part of the attitude and expectation of nurses, physicians, patients and the public, nursing will make its true contribution to society.

To Be Needed

Something called *nursing* appears to be needed. The evidence of this need is all around us. Perhaps the most dramatic evidence can be found in the New Brunswick Hospital Insurance and Diagnostic Services Act of 1958, wherein participants are assured by law of "necessary nursing service" within the general hospital system.

We seem to be positive about the need for *quantity* in the nursing service, yet we are not so assertive when it comes to questions of *quality*. We may pass through trouble and pain before we stabilize the measure of quality of service as rendered by nursing and as needed by the public. It will be difficult for traditional powers to accept nursing's own judgment of the quality of service needed, but such judgment is both the hallmark and the responsibility of a profession.

To Establish Ties

The Canadian Hospital Association with its provincial counterparts and the Canadian Nurses' Association with its provincial counterparts represent our respective established ties. To the extent that one system is dependent upon the other, we have established further ties.

Would you agree that the ultimate criterion of success in nursing is the measure of efficiency with which the nursing system can function in the hospital environment? Would you agree, as nursing moves towards maturity and hence towards professionalism, that resistance to change has and does occur?

If change in relationships is the product of the social system itself, is it reasonable to expect all who are affected by the change to understand

the social forces that are at work? Old authorities and old concepts of authority roles are changing before our very eyes. What we need now is a clearly understood mechanism that results in a proper balance between control over one's own work and the control one is required to accept from a higher authority. For example, we both have an obligation to society through our group relatedness, to check and to balance the power of the hospital insurance system. Failure to do so may result in the development of a hospital system that is anything but the product of a freedom-loving democracy.

To Be Understood

One only understands the things one tames.

When India gained her independence 14 years ago, one of her nurse educators, studying at an advanced level in an American university, remarked:

> Our nursing leaders must take care to see that nursing developments reflect our new constitution.

Think of that! Imagine being careful to place nursing within the social and political context of a constitution! Do nurses in general understand nursing in this sense? Are we careful to see that nursing reflects the values of our culture? Can others accept the shifts and subtleties of changing values in the culture?

Since hospitals have shrugged off the mantle of charity and assumed the mantle of big business, the nurse as a "charity image" in the economic sense exists no more. Nor is it a reflection of our cultural values for women to assume a subordinate role. Women, no less than men, have "a contract with life" subject to responsibilities as well as privileges. Whether for reasons of biology or culture, financial remuneration or status, nursing has remained a feminine institution, and Canadian nurses reflect the status of women. Nurses need to be aware that old discriminations are breaking down, and that "ability" has become the criterion of role. Some people are aware of this. For example, some directors of nursing service in our hospitals now wear the mantle of the vice-president of big business with success. Some nurses have retained our former role of administrator of the hospital. This is not surprising. It is within the nature of our work that we not only nurse the sick, but administer, through a hierarchy of organization, the nursing service of the hospital.

We need to understand the cultural values that impinge on nursing. We need to make sure that we have the ability for our great variety of roles, or we may all have to lie down in the grass and cry!

What Must I Do To Tame You?

You must study, learn, be patient, be constant, be thoughtful, and you must spend time with me.

In nursing, the mixture of service and education is so very visible to the eye. To bring up the separation of education from service is to bring up an old and thorny question. Kathleen Russell refers to this as the 30-years' war.[4] We only have to reread the Weir Report of 1932 to agree with her.

Education should be discussed on the basis of principle. It should reflect the sum of educational purpose in the light and spirit of this day and age. While we always hope that needed change can come about through devoted efforts in behalf of educational purpose, we suspect that it may be earthy finances that will turn the trick. Under our present hospital insurance system of finance, in which the replacement value of services rendered by the student is a factor, three possible situations are:[5]

> 1. Real money is involved as a legitimate cost of education if the cost for each student exceeds the replacement value of the service she renders the hospital.
>
> 2. Overpayment is absorbed in the operational cost of the institution if the student's service to that hospital exceeds the cost of her education.
>
> 3. The student has paid the entire cost of her education if the service rendered by her to the hospital equals that cost.

The Russell Report observes:

> Where the hospital has taken its responsibility for students seriously, the school has been a very expensive asset, and, fortunately, the wisest hospitals

are beginning to question the whole procedure. Meantime, change has been approaching and the old system is faced with opposition which has come in various forms.

If a system is in pain or trouble, "resistance occurs when a proposed change seems to promise benefits to one part at the expense of another."[6] Is it difficult for those who resist needed change to visualize the unknown state in which things will be better? Surely corrective action in the presence of the difficulty can be undertaken by all those concerned. Surely our collective mind can forego tradition and overcome power positions if the end result will mean better nursing service. Surely it is self-evident that the quality of nursing service will diminish in ratio to the poverty of educational opportunity.

Pressure to change seems to come in cycles. Right now nursing is under pressure and it is under study by its own members. Everett C. Hughes, University of Chicago, says, "that nurses are now the most self-conscious of all professional groups." Does this imply that they are more aware of how rapidly changing society is affecting them? Are they more anxious than members of other professions to cope with these changes?

Mr. Hughes also says:

> Some may yearn for the day when a nurse never talked back to her elders or betters, including physicians, and took thought neither for the number of hours she worked nor for the slimness of her pay envelope. They yearn partly for a myth and wholly in vain.[7]

Part of the complexity of nursing lies in the variety of relationships that we are required to set up. When one talks about keeping nursing in *its place*, one calls to mind such a maze of places — the young to the old; the male to the female; the nurse to the doctor; the colonel to the captain; the director of nursing to the interne; the nurse administrator to the board of management — that one is confused by the rebuke. So it is when hostility is expressed to a study of nursing by the organized profession. It seems fair to hope that any reaction will be coupled with a reasonable estimate of the current social pressure on nursing. It is always possible that the blueprint for the future will be found in these studies that Canadian nursing is undertaking even now. We need the support of the hospital, the university, and the whole educational framework of the land.

So far I have dealt with the profile of change in nursing. What of its face? Some of it is in the shadow of the unknown, but we have three groups already in the nursing family, differentiated on the basis of educational content, native ability, and opportunity. We have university education for undergraduate students and for graduate nurses. We have the registered nurse from hospital schools and the so-called independent schools. We have the registered nursing assistant from hospital, vocational and technical schools. We have Master's degree programs for nurses opening at Canadian universities. We have some nurses studying at the doctoral level. We are producing educators, administrators, researchers, authors and professional practitioners.

From this, the point should be spelled out that we must equate our educational content to the potential ability of the student who chooses nursing, for her own sake and for the good of society. Here we are skirting the question of the philosophy of education, certainly a topic for our exclusive attention.

One example of this is the need for professional nursing to be in possession of a broad general education. In reply to the question, "why should a nurse study English literature at the university for three years," a professor of English said:

> The primary function of the study of English literature, as of all the humanities, is to develop a balanced, mature, sensitive and humane person. Literature, as the accumulated wisdom and emotional awareness of the race, enables an individual to understand herself more fully, to be aware of the needs and aspirations of her fellow human beings, to appreciate more fully the beauty and complexity of her physical environment, and to respond more vibrantly to her spiritual environment and her Creator.
>
> In addition, it enables her to participate in the tradition of her people, to have an awareness of the past, and thus

to plan more knowledgeably for her present and her future. Finally, the study of the masterpieces of the past and present should encourage the student to express herself more clearly and forcibly, and to take fuller advantage of the rich potentialities of her language.

Do you think, if we tried very hard, that Canadian hospitals and Canadian nurses together could locate common goals and proceed to guide and direct the immediate course of events? Nursing appreciates only too well the difficulty in visualizing the unknown future in which nursing education and nursing service will change. However, we are expressing a conviction, not a platitude, when we say that better nursing service will come through better nursing education.

We need each other in our pursuit of the future. Remember the secret. *We are responsible forever for what we have tamed.*

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KATHERINE E. MACLAGGAN, M.A.

Occupational Health in Saskatchewan

N. WILLIAMS, M.B., B.S., D.P.H., D.I.H., F.A.C.P.M.

Basically, the objective of an occupational health program is to protect and promote the health of persons while at work.

SO OFTEN PEOPLE politely suggest that, as there is not much industry in Saskatchewan, there would be little for an occupational health or hygiene unit to do. Be that as it may, the fact remains that such a view as to the necessity for an occupational health program misses the broader concepts of this special field which should aim to cover all gainfully employed persons whether they work in industry, mines, agriculture, commerce, or the professions.

Another misconception concerning occupational health can be illustrated by the results of an encounter with a senior physician. After I had introduced myself as the director of the occupational health branch, he politely informed me that there would be little need for my services as the hospital did not go in for basket-making, weaving or rug-making! Even after I had explained what occupational health was, he was still of the opinion that we had nothing to offer in the hospital as they had no health problems among the employees! Presumably, they relied upon corridor consultations for health maintenance of their staff. This type of encounter could be discouraging if we were oversensitive and did not approach our work with at least some sense of humor.

Perhaps the terminology used to describe this special field should be clarified. Occupational health, occupational medicine, industrial health, industrial medicine and even industrial hygiene are commonly used terms. For all practical purposes they are interchangeable with perhaps the exception of the latter, industrial hygiene, which is generally confined to one part of an occupational health program — evaluation and control of the work en-

vironment. The technical work is undertaken by the industrial or occupational hygienist.

The professional members of the team are the nurse, the hygienist and the director. These three specialists constitute the nucleus of any occupational health unit and are an essential minimum for carrying out an effective program. The duties of the occupational hygienist include:

> Collection, analysis and evaluation of dust in the working environment, including mines; sampling the work environment for contamination by gases and toxic vapours; estimation of the hazard existing from physical factors such as noise, vibration, and ionizing radiation; evaluation of the work environment for thermal comfort and heat stress; measuring, evaluating and advising in relation to lighting.

The occupational health branch acts mainly in a consultative and advisory capacity. General experience supports the belief, that if occupational health personnel are to be maximally effective, this approach, and not the inspection or police system, is the only one that will ultimately achieve the objectives of the department. What we have to do with industrial managements is to point out that when certain protective measures are necessary, it is within their enlightened self-interest to comply. In other words, both the industries and the employees stand to gain. Ill health or sub-health among employees is a luxury that no industriy can afford. There is almost never a conflict of interest between management and employees on matters relating to the protection and promotion of the health of working people. There are one or two fields in which it is necessary to have regulations. One of these is radiological health. However, it is intended that these should be thought of rather as a code or guide to the standards necessary for the protection of all groups who may be exposed to ionizing radiation. Only when all means of education and persuasion are of no avail should legal action be taken.

This branch also acts in an advisory and consultative capacity to other governmental departments with an interest in occupational health and safety. These include the Workmen's Compensation Board, Departments of Labor, Mineral Resources and Agriculture. When physicians in Saskatchewan have problems concerning the diagnosis and etiology of diseases suspected of being occupational in origin, the occupational health branch is available to give advice and, where necessary, to conduct environmental surveys and analyze biological specimens in order to make a correct diagnosis. Of no less importance, are the steps that it takes to institute preventive measures to correct the conditions that were responsible for the occupational disease.

Occupational conditions are not the only ones in which the occupational health branch is interested. It is equally interested in the influence of the work environment as a factor in the etiology of disorders that are common to persons in all occupations. The branch has direct responsibility for the medical supervision of workers in potentially hazardous trades. This includes the supervision of the health of miners; workers using certain organic phosphorus insecticides; workers in poultry processing plants exposed to the risk of contracting ornithosis, also known as psittacosis.

Because of the importance of the development of the correct approach and the right attitudes to occupational health by physicians, the information given to medical students is an essential part of their program.

Several business executives, recently interviewed on television, agreed that what a man knows at age 25 is not nearly so important to his ultimate success in business as what he studies after 25. The person who will amount to anything will continue to learn all through life.

— *Adult Education Today*

A Seattle surgeon has fashioned a functioning leaflet for a damaged mitral valve from a patch of pericardium measuring a little more than an inch wide by an inch and a half in length. The 52-year old patient, who was completely bed-ridden prior to the operation, is now doing her own housework.

— *The American Heart*, Vol. XI, No. 3

Occupational Health Nursing in Saskatchewan

JEAN WOODS

Since it is one of the three prairie provinces many people do not associate Saskatchewan with any kind of organized industry. It may be difficult to imagine that besides the many small industries that exist there are some large enough to have health services and to employ nurses.

THE FIRST PART-TIME occupational nursing service in Saskatchewan was purchased from the Victorian Order of Nurses by the T. Eaton Company, Saskatoon, about the year 1922. Part-time service to the Hudson Bay store in Saskatoon began in 1937 and was also supplied by the VON. According to available information, the first full-time nurse was employed by Simpson's Ltd. Regina in 1942.

Compared with other provinces there are relatively few nurses employed in occupational health, approximately 18 in all. The agencies employing them include meat packing plants, oil refineries, department stores, a warehouse that fills catalogue orders, and the employee health services of hospitals. The VON still supplies part-time service to some employee groups and there are first-aid men employed by the uranium and potash mines. Nurses are also employed, periodically, on construction sites, as, for example, when dams are built or power plants erected.

As a member of the Occupational Health Branch of the Department of Public Health, my main responsibility is to give every possible assistance to nurses working full or part-time in the occupational health field in order that they may have a better understanding and knowledge of their functions and responsibilities, thus giving better service to the industry and its employees. An initial survey of occupational health nursing in the province disclosed that nurses were carrying out programs that varied from simple first aid to a comprehensive service. Where health services were restricted it was usually due to lack of awareness of the role of the occupational health nurse by management, by the nurse herself, or by both. Lack of medical supervision is a naturally restricting factor.

Programs and Personnel

Programs will be found to include all or some of the following:

1. Medical examinations — preplacement, periodic, special
2. Emergency care for illness and injury
3. Counselling
4. Health education
5. Record keeping
6. Participation in the accident prevention program
7. Supervision of sickness absence
8. Home visiting
9. Administration of the health centre

Of necessity the initial concern of management is the immediate and effective care of occupational injuries and illness. It is also concerned with non-occupational injuries and illnesses, whose disabling effects are frequently far greater than those of occcupational origin. The amount of time spent on emergency care influences the rest of her program but the nurse who is concerned with keeping her people well and happy realizes that there is more to her job than the immediate application of a bandage for a cut finger or the administration of an aspirin, even though these are essential functions.

For nurses who wish to enter the occupational health field there is no special preparation available in Canada. Postgraduate study in public health is advised at the present time. In Saskatchewan, there are one or two nurses in occupational health who have had public health preparation or experience. Most of the occupational

health nurses have gained their experience on the job.

The Consultant

In the spring of 1958, when I first joined the Occupational Health Branch that had been set up in July of the previous year, it was necessary to introduce a program designed to keep all nurses in the field in touch with new trends and ideas and to bring them together as much as possible so that they would not feel isolated and cut off from professional contact. It is quite easy to "get into a rut" when you work alone and without supervision.

The following is an outline of the program to date:

1. Visits are made to nurses in industry on a routine and request basis to assist with problems and to discuss new ideas.
2. Standing orders were drawn up to serve as a guide to those nurses working without medical direction.
3. A nursing bulletin, the *Saskatchewan Occupational Health Bulletin for Nurses*, is published about three times a year, with articles and items of special interest.
4. Twice yearly meetings of all occupational health nurses are held. Subjects such as mental health, alcoholism, skin conditions, eye conditions and artificial respiration are discussed. The employing agencies have been most generous in making it possible for their nurses to be present at these sessions.
5. Articles of interest are mimeographed at headquarters and nurses are kept supplied with pamphlets, literature, etc., pertinent to their work.
6. Special help has been given to nurses setting up new health services or to those without previous experience who are appointed to existing services. Advice has been offered on health centre layout and equipment.

Possibly there is no way of measuring adequately the effectiveness of a consultant service, but it is felt that some progress has been made. The response of the nurses to the service has been encouraging.

Records and References

It is understood that all nurses are now maintaining records, adequate for their own particular service. These include personal records as well as those for statistical purposes. *Records for Occupational Health Services* prepared by the Division of Industrial Hygiene, Ontario Department of Health has served as a very useful guide. Most nurses now have a manual, for their particular health service, in varying degrees of completeness. This is probably the most useful tool for the nurse to use in evaluating her service, and enlarging upon it. It should also be possible for a new nurse to take over an employee health unit without any lapse in service, using the manual as a guide. The *Guide for the Preparation of a Manual of Policies and Procedures*, prepared by a committee of senior occupational health nurses in Canada under Miss Mildred Walker's chairmanship, is invaluable. This committee is to be congratulated on its contribution to occupational health nursing.

In 1960, the Canadian Medical Association produced *Guiding Principles for the Provision of Occupational Health Services*. Certain basic principles were outlined to be used as guides in establishing programs. This has proven useful when industries have wished to enlarge their existing services or when attempts have been made to interest managements in instituting health services.

Much guidance material related to occupational health nursing and health services has been produced. This material has been assembled in a *Reference Handbook* for occupational health nurses by the nursing consultants in Canada. The objectives of the handbook are:

1. To be a reference source in occupational health nursing.
2. To be a means of renewing and increasing nursing knowledge in this field.
3. To aid standardization of knowledge and practice in this specialty.

Health Education

Nurses are doing as much as possible in health education and counselling. Each visit made by the employee to the health centre is an opportunity for education and guidance. In addition, nurses have used displays of posters and pamphlets, given talks, demonstrations and showed films.

They have also written articles for company magazines and for distribution.

The nurse in industry realizes that she is a part of a health team, even though she may be the only professional health worker at the place of employment. She is only partly responsible for maintaining the health of employees, although she may coordinate the efforts of others such as plant managers, personnel managers, safety officers and supervisors. Outside the plant the team is made up of family physicians, public health workers, hospitals, the numerous welfare agencies and others. In order to function effectively the nurse realizes that she must have knowledge of and established good working relationships with all members of the team.

In an attempt to acquaint as many people as possible with the work of the occupational health nurse, lectures, films and panel discussions have been presented to such groups as the members of the SRNA, the Saskatchewan Hospital Association, public health nurses and graduate students, hospital students and management groups. Personal interviews and advice have also been given to representatives of management. Student nurses at the University of Saskatchewan have contact with the University Hospital employee health service, which is a comprehensive one. Several schools of nursing in the province now arrange for their students to make observation visits to local industries that have health services and employ a nurse.

The following statistics show the numbers of workers covered by an occupational health service:

Approximate total population (1960 census)	910,000
Non-agricultural labor force	191,000
Agricultural labor force	115,000
Total labor force	306,000
Total number of workers supervised by full-time occupational health nurse	7,500
Total number of workers supervised by part-time nurse	1,000
Total	8,500
Total number of workers (non-agricultural) not supervised by nursing service	182,500

It can be said that, excluding certain teaching hospitals and most of the government agencies, all industries employing 250 or more people have some form of employee health service and most employ a nurse. How to bring occupational health services to the smaller groups still remains a problem.

Coming!

IN DECEMBER, 1961

Guest Editor — Dorothy M. Percy, Chief Nursing Consultant, Dept. of National Health and Welfare

McLaughlin — Prenatal Care

Amyot — Pregnancy and Diabetes

Allen — Pregnancy and Muscular Dystrophy

Assumpta and Howard — Abdominal Decompression

Goos and Paul — An Obstetrical Problem Solved

A series on the work of Chaplains in Hospitals *plus additional material*

Occupational Health in the Hospital

HELEN HOBBS

Hospitals that wish to set up health services for their employees can obtain much help from the experience of industry.

Health Service Characteristics

IN A HOSPITAL, as in industry, it is expected that the health service will benefit all employees, sick and well. Its objective is to *help* the employee, not to discipline him. This is a concept that needs interpretation. The concern is as much for prevention of illness as it is for treatment. The aim is to assess the health of an employee when he first comes to the hospital and to maintain, and if possible improve it, while he is there.

What is the difference between an industrial and a hospital health service? Basically they are the same but there is more emphasis placed on certain program areas because of the hazards peculiar to hospitals. The hospital employee has less accident hazard than the one in industry, but he is more exposed to infection.

In addition to the health of the employee, the patients' health and safety must be considered. Industry concentrates on putting out a good product. The hospital's product is the patient who is well on discharge. A nurse, intern, dietary or housekeeping staff member, working while suffering from a boil or paronychia can double the cost of a patient's hospitalization if this infection is passed on. The entire staff must be educated to report infections and to obtain early and adequate treatment.

Another factor affecting the hospital health service is the presence of student nurses. What can the student or graduate nurse and auxiliary personnel learn from their experiences with a health service that will help them to give better patient care? If they are caring for an employee from the laundry who has injured his arm in a machine, will they think more about how this man's job affects his health? Will they consider the safety factors? Will they consider his ability to return to the same job? Will this experience carry over in their care of other patients? What about the watchmaker who has been hospitalized with an eye injury or glaucoma? How will this affect his family and his livelihood? Surely all of us who have any responsibility for hospital teaching can help to foster this type of thinking.

The student who is convinced that routine examinations, early, adequate treatment, and counselling are good things for herself, cannot help but be convincing when she advises the same for her patients.

In a hospital, it should be considered that the staff is 75 per cent female. This may affect the absenteeism rate since most industrial surveys show that women employees have a higher record of illness than men. Reasons for this are apparent when one looks at the groups of women employed in hospitals.

1. There are the young, unmarried girls who, for various reasons, do not wish long periods of employment. Jobs are not hard to find and they move around. Many live alone and exist on hot plate cooking. They are not nearly as concerned about nutrition when it is an individual matter as the mother of four children would be. These girls are very active both on and off duty. Consequently they are prone to fatigue. They have a fair amount of absenteeism from colds and minor illnesses.

2. There are the working mothers who often are fatigued simply because they are doing two jobs. Here we are concerned with the problems of pregnancy and other conditions. Referral to physicians, prenatal classes, family welfare and home nursing agencies is sometimes indicated. This is a valuable working force but one that needs health supervision.

3. There are the older women who are working mainly for financial reasons at a time when they are not at the peak of physical condition. Most of them have to accept on-the-job training. They work in such areas as dietary, central supply, housekeeping and laundry. It is not easy to go back to working under close

supervision, if they have been independent for many years.

Again there is frequently cause for medical referral. Such an employee may say very casually, "Should I see a doctor about this, nurse?" The nurse may find the symptom quite alarming and wonder why she should even ask. There seems to be the need to have someone to bridge the gap between the patient and the doctor. In the past five years the Health Service at University Hospital has referred several employees to their family doctors who were subsequently treated by the cancer clinic. The majority were in the working mother and older age groups.

The educational material available from the provincial Department of Health is most helpful in relation to pre- and postnatal teaching, nutrition and various diseases.

Finally, the great differences in the income and intellectual abilities of the hospital employees must be considered. The occupational nurse must be very flexible in the way that she interprets her program. The janitor who can not read or write English will need his workmen's compensation claim explained in a different way than will the surgeon who nicks his finger on a scalpel blade.

Personnel Benefits

What does a physical examination do for the student nurse or hospital employee? In most student nurse programs, a pre-entrance physical examination by the student's family physician is required. This record is valuable for screening applicants and points up conditions that can be corrected by the family doctor before the applicant begins her training. After acceptance into the school of nursing she is examined by the students' physician, a salaried employee in charge of the health supervision of the entire student group. Follow-up work may again be indicated. The greatest advantage of this examination is that a rapport is established between the doctor and the student that opens the door for future counselling.

Students *do* have problems, both medical and personal. It is their right to have a neutral area in which they can discuss their difficulties, in confidence, with their doctor or their nurse.

Pre-employment physical examinations provide assurance that the staff members are able for the job or, if they have abnormalities, that they are brought under treatment. We must know that they are safe to be working with patients. Many people with disabilities can be employed in a hospital. In University Hospital we have blind boys working in the canteen and in the x-ray dark room; a deaf girl in the printing department and individuals with controlled epilepsy in several areas. This latter group includes graduate and student nurses. With careful placement some stenographers, laboratory technicians and medical staff who come to work on crutches or in wheel chairs, are successfully fulfilling job requirements. A number of patients who have had psychiatric treatment have done extremely well as hospital employees although we have not had quite as good a work record with this group as we have had with the physically handicapped. It has been found that employees with disabilities really appreciate their jobs and have less than average absenteeism.

During employment examination, a handicapped person is greatly reassured if he feels that the hospital is interested in and anxious to help him. It must be interpreted to him however, that his chances of being kept on staff depend entirely on his job performance. Another good reason for this examination is that it gives the hospital a "norm" for an employee that can be used later for comparison if he should become injured or ill on the job. It may be a valuable guide, if he comes up for transfer, since physical requirements vary in different departments.

Any hospital, whether it has an organized health service or not, will benefit by requiring a pre-employment physical examination for employees. It can be provided by the hospital on a voluntary or payment basis, or it may be done by the employee's personal physician. If the latter plan is followed it would be advisable for the individual hospital to design its own physical examination record, asking for information specific to its needs. It is helpful to have a job history, personal information and some assessment of attitudes or mood. If

the doctor, who becomes quite skilful in assessing a person in relation to his job, describes him as being tense, anxious, or depressed, or mentions a family problem, the nurse will be more understanding if the employee makes repeated visits to the health service.

The Safety Committee

Accidents on the job in a hospital, fall into the same classifications as in industry. Nurses, orderlies and porters are prone to lifting injuries. Laboratory and maintenance employees report eye accidents from solutions and foreign bodies. Cuts and burns are common to dietary and laundry areas. An active safety committee, with the support of management, can help to reduce accident costs. The assessment with Workmen's Compensation at this hospital has dropped in the past six years from 30 cents to 15 cents on the $100 payroll. Along with regular inspection tours and investigation of accident causes, our Safety Committee has promoted an educational program. Lectures and demonstrations on good body mechanics have been included in the nursing staff orientation. Similar lectures have been given recently to housekeeping, maintenance and porter groups. A film entitled "How To Prevent Lifting Injuries," obtainable for the asking from The Imperial Oil Co., was shown to the maintenance staff, while the housekeeping staff enjoyed a filmstrip called "Lifting For You and Your Patient." The latter is shown regularly to student nurses. Safety talks on accident prevention have been given to various departments. All staff have an opportunity to see the film on mouth-to-mouth breathing called, "That They May Live."

The material published specifically for hospitals by the American Hospital Safety Service is very helpful. Membership is $12 per year. Posters received from A.H.S.S. are excellent. Much of the material has been easily adapted for our monthly hospital bulletin. It has been interesting also, along with other Canadian hospitals, to participate in the American Hospital safety contest.

A safety committee, to be effective, should not be top heavy with department heads. It should represent all hospital areas. If the man-on-the-job becomes safety-conscious through his participation on the committee, he will spread the concept to his fellow employees.

It may be asked, why bother with a health service if you have an emergency department in the hospital? It is true that the nurse in emergency can do just as good a job of bandaging a cut finger. The nurse in an employee health service, however, knows the individual's total medical picture. She may use this opportunity to discuss some other aspect of his health that may be much more important than the condition requiring immediate treatment. Was he able to keep that appointment with his family doctor?

Infections

One of the greatest hazards to hospital personnel is still the undiagnosed tuberculosis patient. The number of tuberculosis cases found among general hospital personnel is still higher than that among sanatorium employees. In 1959, in Saskatchewan, four times as many active cases of tuberculosis were found on hospital admission plates as were discovered on provincial survey. In the central Saskatchewan area, seven unsuspected cases were discovered through admission x-rays. This does not include the total number of suspected cases admitted to hospital for diagnosis.

Next to nursing staff, laundry employees are reported to have a high rate of contact with tuberculosis. Because other personnel in housekeeping, dietary, physiotherapy and x-ray departments are also in contact with the patients, we feel that all of our employees in University Hospital should be protected. For this reason the B.C.G. vaccination program, formerly provided for student nurses only, has been extended to all employees.

The Saskatoon Sanatorium reported in 1960 that it had no student nurses under treatment for tuberculosis at that time. As of the same date, University Hospital had been equally fortunate in not having a case of tuberculosis among student nurses since the school opened in 1954. There have been three cases in the employee group.

Poliomyelitis was reported in Saskatchewan as late as October 1959 and as early as April 1960. A fourth in-

jection of vaccine was provided for all student nurses and hospital employees. This appeared justified when it was considered that the cost of treatment for one staff member with paralytic polio would far outweigh the cost of providing immunization for 1200 employees and students. Hospital employees require a concentrated educational program to keep them aware of the need for protection for themselves and families. Similarly, accurate records of vaccination are requisite.

Other Hazards

Another risk to female hospital employees who may be in the first trimester of pregnancy is exposure to the virus diseases found in the pediatric area. For this reason uncomplicated cases of German measles, chicken-pox, and so forth are sent home in order to limit contact with nursing staff and others. Married staff and nursing students are being educated to protect themselves in this regard.

Staphylococcal infections within hospitals are a general problem. Isolation of patients, adequate reporting and treatment, and keeping employees with draining lesions off duty, are essential measures. The use of staphylococcal vaccine for students or employees with recurrent infections has been warranted in our experience. A three-year survey showed a marked decrease in incidence among 70 per cent of the group treated. One student who had frequent infections and did not respond to toxoid was found to have a low gamma globulin blood level. She has been free from infection since receiving an injection of gamma globulin.

If hospitals have laboratory facilities, throat swabbing will reveal occasional hemolytic streptococcal infections. Adequate treatment is essential if we think in terms of prevention of rheumatic fever and other complications. Student nurses receive a 10-day course of penicillin as prophylaxis if they are found to have streptococcal infections. Employees are referred to family doctors. A group that requires protection against tetanus are the student nurses since they are prone to sports injuries and the maintenance staff who may receive contaminated puncture wounds.

Workmen's Compensation benefits for hospital employees have been excellent in this province. In the past three years they have been extended to those who contract staphylococcal infections, including pneumonia, while they are caring for isolated patients. Boils or skin lesions must be in an exposed area if the claim is to be considered.

X-ray hazards must be considered in the hospital setting. Exposure indicators for x-ray technicians must be carefully checked. It is important that all routine annual chest x-rays should be taken with a lead screen so that only the chest area is exposed.

A pamphlet on x-ray and radiation hazards is of interest. It is called *A Practical Manual on the Medical and Dental Use of X-rays with Control of Radiation Hazards.* It was prepared by the American College of Radiology and is available from the Saskatchewan Department of Health.

Conclusion

In summary, a hospital health service concerns itself with prevention of illness, counselling, emergency treatment, referral for treatment, adequate records and research. This is only part of its function. Perhaps you are familiar with the quotation: "Experience is not wisdom but material for thinking with."

We hope that the student nurses' and employees' experience with a hospital health service will give them *"material to think with."* If sufficiently convinced they will, in turn, pass on their knowledge to patients, friends and families.

"Your Cholesterol Depressant Diet Cook Book," a free publication, features menus, recipes, diet and cooking guidance, all arranged according to levels of 1200, 1800 and 2600 calories per day. For copies write to: Wesson, 210 Baronne St., New Orleans, La.

The eye is the star recorder of the human mind; it brings us more than 85 per cent of all the information we store in our minds.

* * *

Any landscape is a condition of the spirit.
— HENRI-FRÉDERIC AMIEL

HEALTH GOES TO WORK

MILDRED I. WALKER, M.A.

It has been said that it takes 15 years for a new idea to be accepted and another three years to put it into practice. This may be applied to the concept that the administration of health services is most effective when planned around the total family as a unit.

IT WAS ABOUT 20 years ago that instruction to public health nurses in universities began to be based on the family unit. The family circle as related to traditional public health services will be complete when health services to citizens include occupational health. Then we can say truly that health goes to work. Our awareness of the importance of extending health services to the total family can be demonstrated by the following:

1. In the Baillie-Creelman report, of a study of public health practices in Canada, there is a chapter devoted to the nurse in industry. In it, Miss Creelman observes that when the public health nurse visits in a home, the absent member is the breadwinner. This absent member may be at work in industry where there may or may not be an occupational health service. If he works where there is a health service, it is usually in an industry with more than 500 employees. What about the smaller industrial groups? These make up more than 50 per cent of our employment units. The City Health Department of Kitchener-Waterloo, Ontario has a program that provides consultant services to small industries without as well as large industries with health services. In the administrative planning of these cities, the members of the family at work are considered. Other cities in Canada are developing this same concept.

2. One statement made at a panel discussion on "Men, Management, Machines and Mental Health" is applicable here. Dr. Clarence Rowe of Minnesota, a medical educator and psychiatrist noted that medical education had gone through two stages:

(a) the organ-centred era
(b) the individual-centred era
and is now in (c) the family-centred period.

How long it will take to have this latter concept accepted, remains to be seen.

It may be that a completely family-centred program is not feasible under present public health administration planning. However, the concept that the family is the concern of everyone in the health field is realistic. This includes all nursing services. The nurse in a hospital service has the sick member of the family under her supervision. He may be the breadwinner. If so, the family income will be changed. This is one of the most distressing factors in family living.

The Family-centred Concept

The primary function of the family is procreation of the race. It nurtures each child to become increasingly self-dependent according to his abilities. This is the prime responsibility of the parents in a democratic society. Sometimes, parents cannot supply the emotional and physical nurture. This must be done by an outside agency.

Surrounding the family and lending support are the agencies that assist with the secondary functions: 1. Education; 2. recreation; 3. religion; 4. economic; 5. protection; 6. status. In modern living these agencies are dependent upon the attitudes and resources of the community. The pioneer family developed them within the home.

In health programs our function is *protective*. Fire and police departments fall into the same category. In *occupational* health services, there is an added responsibility, that of strengthening the economic function of the family.

Occupational health is a continuation of health services from school to work. At present, our health programs give greater emphasis to prenatal, natal, infant, preschool and school health services to the end of

the secondary school period. Then the young adult is presumed to be ready to assume responsibility for his own health. He may go to university, enter teacher training, stay on the farm or go to work in an industry. Wherever he goes health, emotional and physical, goes to work with him. How adequate have the health maintenance programs been?

Occupational health is a health maintenance service provided by professional medical and nursing personnel to the adult members of a family, who are gainfully employed. Because of the trend for many mothers to go to work, there is need for closer integration of occupational health with other health services in the community. The term *community health agencies* includes hospitals, and other institutions that care for the sick or infirm.

Although Canada has not had a recent statistical survey, it is believed that less than 5 per cent of manufacturing industries, or about 30 per cent of employees in the population have health services available to them through their place of employment. Usually plants of 500 or more have a full-time nurse and part-time doctor. Larger industries have full-time medical officers and supervising nurses.

Scope of the Service

1. Health examinations.
2. Emergency care for occupational and non-occupational accidents or illnesses.
3. Cooperation with company personnel responsible for supervision, safety, nutrition, sanitation, plant housekeeping, ventilation.
4. Health education and counselling.
5. Cooperation with community agencies.
6. Administration, including general management of the programs, records, reports and integration of services within the company's public relations program.
7. Home visiting and supervision during illness according to well-defined company policies.

Community Health

1. Health services influence employment policies in several ways:

Health examinations determine a man's health potential.

Illness, properly interpreted, will assist employee and management to respect the person as an individual.

There is support for a person through the ups and downs of life.

Work is essential to health. A health appraisal can and does strengthen man's motivation to perform a good day's work.

2. Awareness of job demands on the work force is created:

The resources in the population of a community from which employees may be drawn — the potential work force — is shown. In locating a new company, the potential of manpower in the area is assessed before a decision to build there is made.

3. Assessment of attitudes to health and work is a part of the manpower inventory:

Health education in industry takes into account the degree of exposure of the employee to health teaching throughout his life cycle. This reflects the quality of the community's health services over the years. It includes such factors as the type of food production, the weather, the geography and topography and their effect on the people.

4. Self-sufficiency is encouraged.

A man accepts a job with the understanding that he has a responsibility towards production in the work force. Management has certain responsibilities, too. One is to share in the rehabilitation of sick or disabled employees.

5. Safety factors in the environment are considered.

If the work is dangerous, management must supply protection. Man needs to feel that he has a relatively safe working environment, that the hazards are under control. Where the work is dangerous, management shows its sense of responsibility by the enforcement of protective measures. This is one of the greatest means of increasing morale and loyalty. A safety program improves working facilities. Its influence will extend to the homes of the employees. Health service personnel make an important contribution here.

Good employment relations will influence the economic and social status of the community. In turn, the community must appreciate evidence of the sincerity of good human relations in an employment situation.

6. Company statistics indicate fac-

tors that influence economic and social status.

Records of the health index of the people; their resourcefulness; racial, religious and educational backgrounds; age; marital status; the sex of the employees, are available for study.

Health statistics of the general population

Age 55 - 59 . . . 12.7 days illness per year.

Age 20 - 34 . . . 5.3 days illness per year.

45 per cent have no illness absence. What kind of people lose no time? Do they have recognition for this achievement? We need to learn more about this group.

7. The productiveness of handicapped persons will be strengthened. When properly placed in a job, the handicaps disappear as far as employment is concerned.

8. Interpretation of health, illness and hazards in the work situation are the responsibility of occupational health personnel.

9. Stimulation of research to establish the relationships between disease, health and occupation is a professional responsibility of occupational health personnel.

Community Benefits

Company policies influence the practice of medicine and health. They influence standards of medical care through good occupational health supervision and through interpretation of job requirements to allied professional groups. They influence the type of people and the attitudes of those who apply for work. They will promote mental health, encourage creativity, induce a feeling of belonging and the joy of achievement for the employee who will know that he has done a productive day's work for which he is respected. This in turn influences the mental health of the family.

Good policies influence the level of income and the family status as well as the level of health protection. They strengthen community resources towards more gracious living.

New Views and Trends

1. There is a greater emphasis on wellness. This is difficult to measure. The suggestion has been made that we should study the person who loses no sick time, and who appears well.[5] What are his characteristics? Who is he? The wellness approach conserves human resources. At present, the health services to adults are concerned largely with tuberculosis, cardiac conditions, diabetes and orthopedic conditions, except in occupational health programs, which are usually privately sponsored.

2. Work is essential to health. Brockington contends that "occupation is an essential ingredient to health. Since man is a social animal, he must have an object in life, otherwise he dissipates his strength in irregular pursuits or decays from listlessness. Man's difficulty has been to seize the benefits of occupation without taking on its dangers. Work should not cause illness, but rather health."[2] We suggest a partnership of health and work. To accomplish this, there is need for an increase in qualified personnel to interpret, encourage and promote health in the work environment.

3. There must be conservation of health services and of the personnel who give the service. At present there are not enough health workers to meet the demands of our society, nor will there be for a long time. To meet present needs, there must be closer correlation, integration and ethical referrals to the experts.

4. The increased responsibility to be assumed by each individual for his own health will decrease the number of dependent citizens. This is an area in which industrial management can give leadership. Management expects that when a man accepts a position and is carefully appraised when employed, he will assume responsibility for doing the job. If he has a health problem, he is expected to seek medical care, then to assume responsibility for a return to health and efficiency. For example, management expects the employee to assume responsibility for proper nutrition, rest and recreation. He is given guidance, education and encouragement from the personnel in the health centre.

5. Conservation of human resources will come through employee health services extended to all citizens at and through their employment. Steps are being taken to publish a guide for hospital employee health services. Dr.

Felton points out the excellent health maintenance of student nurses.[3] He feels there should be services of the same high quality for *all* hospital employees and for other students. It is one means of conserving scarce and essential personnel.

6. More and better qualified personnel should be provided to give health guidance at and through places of employment.

7. Health and welfare administration can be strengthened by assistance from members of management. Industral managers have learned to conserve well-qualified personnel and to show respect for the work they do.

In planning the inclusion of occupational health in the general community services, the employment situation should be considered from these aspects:

1. Management must have a profit to remain in business.
2. Management has an obligation to the community to stay in business.
3. The community has an obligation to cooperate with management.
4. The attitude of the community to the workers is important to economic and social status.
5. The economic function of the family needs to be supported and encouraged by community public health agencies. Where the family income is adequate and consistent, the health message is accepted more readily.

Occupational health is good business. The health resources of the future will go to work with a purpose.

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IN THE GOOD OLD DAYS

(*The Canadian Nurse* — NOVEMBER 1921)

Application for reciprocal (registration) certificates without examination are becoming very common in those provinces where there is registration, and show the need of having it universal throughout Canada. We hope, before many years, a standard registration law for the whole Dominion may be enacted which will standardize the requirements and in that way will have a like effect on the training schools of Canada.

* * *

To the private duty nurses — Now, that we, private duty nurses, have been accorded the privilege of having our own pages in *The Canadian Nurse,* we may utilize for our mutual improvement, the incalculable influence of the press . . . Every private duty nurse may consider it not only a pleasure but a duty to avail herself of this privilege.

Every nurse has ideas which would be helpful to all the rest of us, and which we greatly need. Let us all resolve that we will do our very utmost to uphold the hands of our editor (what editor can make a paper without material?) and to make our pages in the magazine as profitable, instructive and interesting as possible, not for ourselves only, but for others!

* * *

An age limit has been put upon those registering for the public health nursing course, Dalhousie University and the standards of preliminary education have been raised. A series of lectures on the "Conduct of Nutrition Classes" has been added and the number of lectures on "Psychology and Mental Hygiene" has been increased to 12. There has also been addition of two lectures on "Recreation" which covers the organization of Boy Scouts and Girl Guides, and organized playgrounds, as it seems most necessary that nurses working in rural districts should be able to guide the community in these activities.

PSYCHOLOGICAL PROBLEMS in General Hospitals

JEAN DORGAN, B.A.SC., M.S.W.

The patient's stay in hospital may be complicated by irritations of a minor or more serious nature.

THE WORLD FEDERATION FOR MENTAL HEALTH, as a contribution to World Mental Health Year, decided to take an international look at mental health in general hospitals. The co-operation of two other bodies, the International Council of Nurses and the International Hospital Federation, was secured and the study proceeded under the joint auspices of the three bodies. Responsibility for the organization of study groups in Canada was delegated to the Canadian Mental Health Association, the Canadian Nurses' Association and the Canadian Hospital Association. Representatives of these bodies formed the Steering Committee that was responsible for launching the Ottawa Study Group in April 1959. One of the areas of investigation was in relation to difficulties encountered by patients.

Patients' Problems

The value of questionnaires as a means of discovering patients' feelings elicited considerable discussion. It was felt by some that few patients will risk negative comments in a situation that they cannot control. However, some patients were impressed to learn that their opinions were considered useful. This had a positive effect.

The old familiar complaints about early wakening and cold meals appeared more often than expressions of feeling related to dependency, lack of privacy and lack of interest in the patient as an individual. Apparently most patients need to develop a secure relationship with at least one individual in the hospital before they feel free to say what they *really* think. It was noted that questionnaires often yield dividends. One patient had the courage to complain that the bell in a clock tower, marking the quarter hours, made it impossible to obtain a night's rest. It was promptly silenced. No mean achievement since the hospital was over 100 years old!

Becoming a Patient

Comments concerning admitting procedures stressed the need for privacy, respect and sensitivity on the part of personnel, and the importance of *one* individual being responsible for a patient until he is conducted to the ward where the head nurse takes over. It was felt that the personnel very often have no understanding of interpersonal dynamics and that training in this aspect of their work should be provided.

Information, Please!

Patients and their families frequently experience unnecessary difficulty in securing information from hospitals. A suggested solution was to make one specific doctor responsible for interpretation. This procedure should prevent undue worry on the part of the patient and avoid relatives getting "the run-around." Ward rounds were considered particularly hazardous in creating anxiety. The practice of having an assistant doctor on hand, following the chief's ward rounds to answer patients' questions immediately, was advocated.

Visitors Allowed

Children in hospital are receiving increasing attention. Great Britain seems to have taken the lead in permitting unlimited visiting from parents. By this means, the child who is too young to understand that the separation from his parents is a temporary arrangement, can be protected from worry to a great extent. In Spain, every effort is made to treat children in their own homes, at least until after the second birthday.

Some physicians feel that few, if any, childhood illnesses require visitors to remain behind glass walls or to wear gowns and masks. The frustrations for the child plus the fact that visitors, through lack of understanding, usually

defeat the purpose of such precautions offset any value they might have.

No strong position was taken on maternity "rooming-in." Undoubtedly, some mothers would prefer to be alone in order to obtain much needed rest. This is a matter for individual decision.

With reference to hospital visiting generally, many hospitals now permit unlimited visiting during the day. This has the effect of distributing the strain for both patients and visitors and is preferable to former methods. It did, however, create a problem in a Scottish hospital where, when restrictions were removed, relatives felt it was their "duty" to remain all day! It was surprising to learn that exclusion of children under 16 from hospital visiting is apparently less rigidly enforced in other countries.

Concomitant with relaxation of rigid rules about hospital visiting hours, the feeling was expressed that head nurses should take more responsibility for controlling visitors since patients find this hard to do.

Needs and Nurses

The necessity to respect patients' individual needs while in no way weakening the therapeutic function, which is the primary responsibility of the hospital, was an aspect for serious study. Concern was expressed that, because of the increasing complexity of modern hospital techniques, much of the actual care of patients may be delegated to the staff members with the least training. Communication with this group could be improved. Some doctors regretted the passage of "the good bedside nurse" but were reminded that the modern patient spends very little time in bed!

Considerable attention was devoted to the "dehumanizing" process through which medical and other students pass. As it is a defense against painful situations, it was thought that hospitals could be more alert to this process in order to help students and protect patients. The use of patients for teaching and research purposes was considered particularly hazardous to emotional health. It was suggested that chiefs of staff must be sensitive to this. Patients should not be used for teaching purposes against their will.

The Hospital Chaplain

The relationship of the doctor to the hospital chaplain appears to be under general consideration. The spiritual advisor should have a very real place in the hospital rather than being called only to the gravely ill. He should be a spiritual advisor not a psychological counsellor *per se* although the two roles overlap at times.

Assignment of Patients

In relation to assignment of patients for care it appears that what is best for the hospital and the staff is not always best for the patient and vice versa. For instance, moving patients in stages from intensive care to partial self-care units often causes a few days of depression. Patients do not like being moved. To insist that convalescent and chronically ill patients should be treated in separate institutions may mean that students will gain experience in caring for acutely ill patients only. Patients may respond better when with their own age group but this may require accommodation of surgical and medical patients in the same ward and may result in inefficient use of equipment.

The objectives of a professional education seem to be:

1. Professional competence, or the ability to execute the tasks assigned to the profession;

2. social understanding, or the ability to analyze and interpret and influence the social environment in which the profession operates;

3. professional personality, or the creation of the type of person the profession requires;

4. zest for continued study, or the motivation to continue to seek knowledge and understanding after formal education has been concluded;

5. competence in research, or the ability to conduct research projects or interpret research results.

— WILLIAM J. MCGLOTHIN, quoted in *NLN News*, Vol. 9, No. 4

* * *

Human history becomes more and more a race between education and catastrophe.

— H. G. WELLS

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Word from British Guiana

Away back in 1955, the Rotary Club of Kitchener-Waterloo, Ontario, indicated its desire to provide a fellowship for a nurse from a Commonwealth Country to enable her to study nursing programs in Canada. Through the International Council of Nurses and the Colonial Office in Great Britain, arrangements were made for Miss JOYCE OWEN of British Guiana to spend one year in Canada. Miss Owen spent considerable time with Miss Beamish observing in various services of the Kitchener-Waterloo Hospital. In addition, she observed in various psychiatric hospitals as this was her special field of interest.

Miss Owen returned to British Guiana to be matron at the Mental Hospital, Fort Canje, Berbice. She has written to National Office as follows:

> I wanted to give you an account of how I have profited from my Kitchener-Waterloo Fellowship. To begin with, I must confess that, not having worked in a mental hospital before, I was terribly impressed with my affiliation period at St. Thomas Ontario Hospital where I was oriented to Canadian mental nursing.
>
> The legal aspect of mental nursing was fully brought out, and of course, it plays an important part in any part of the world. At present, we are regrouping our patients, who were previously pushed into any ward, provided there was adequate accommodation for their admission. Today, there are two medical officers, one of whom has worked in psychiatric hospitals for sometime in Edinburgh and London. Our psychiatrist is expected back in August, so along with two ward sisters — English-trained — and myself, we are all looking forward to more strenuous tasks in helping the 750 patients here.
>
> From 1957 February, I started to teach small groups of female and male attendants. Of course it is not a recognized training school, but due to my attempts, I have convinced our Chief Medical Officer and the Minister of Labour, Health & Housing, that it is one of the dire needs of this institution and at present we are getting financial aid or equipment for our classrooms. By September 1961, I sincerely hope that we shall be well established.
>
> Whilst I was at Kitchener-Waterloo Hospital, I learnt a great deal from Miss Beamish. Here I was able to employ some of her methods in my classroom which was not as adequately equipped as hers. Then ward inventories were terribly depleted and badly kept. Today, I am pleased with the supervision of the sewing room and obtain better production from seamstresses sewing for 320 female patients, 78 female attendants and 5 senior female officers. Patients are encouraged to help wash and iron in the laundry — which of course is another form of occupational therapy.
>
> Our diet has improved immensely since our own farms started in February 1958. In addition, we have been lucky to have on our staff (from December 1959 until December 1961) a catering officer so our standard of food preparation and serving has improved immensely; also we had an American nun — Sister Thomasini, who improved on our patients' diet scale. Our farm records show that we produced 21,536 pounds of green vegetables during 1960. This work is supervised by 3 male attendants and 52 patients. From amongst these patients, we find a higher rate of dis-

charges. This farming project reminded me of Verdun Protestant Hospital's farm. They produced their own milk, whereas we produce our own vegetables.

Another form of occupational therapy employed here is knitting, embroidery, raffia work and making objects such as christmas trees, and hanging-pots for plants. During my first year I gave a bazaar, asked each attendant to do something for it and by so doing, I was able to spot people who were ambidextrous. These attendants were then put in charge of projects with patients, and now we are ready for another bazaar and dance to help make additional funds for the patients' entertainment.

For myself, I propose to go on a holiday in the Autumn and perhaps I might be able to renew acquaintances in Canada and the States.

CNA 1962 Convention Vancouver

June 24-29, 1962

It is not too soon to plan to attend the 31st CNA Biennial Meeting to be held in the ultra-modern Queen Elizabeth Theatre, Vancouver, British Columbia.

The Program Committee is giving special attention to the development of interesting plans. Among other presentations, there will be progress reports and discussion of the three special CNA projects — The Study of Nursing Education, The Evaluation of Nursing Service and the School Improvement Program.

In conjunction with the Biennial Meeting, special tours will be arranged. Nurses travelling from Eastern and Central Canada may spend one week in Mexico enroute, at surprisingly little additional cost. There will also be a post-convention tour to Hawaii and, if a sufficient number indicate interest, to Alaska.

Plan now to attend your CNA Biennial Meeting.

Canadian Nurses' Foundation

To facilitate the collection and administration of funds for scholarships and research, National Office staff is exploring the possibility of establishing a Canadian Nurses' Foundation. In addition to the many details involved are the outlining of Bylaws, appointment of a Board of Directors and clearing the project with the Department of National Revenue for the purpose of income tax deductions.

The establishment of a Canadian Nurses' Foundation would mean that the Canadian Nurses' Association could receive gifts, bequests, donations from individuals, corporations, foundations, etc., who wish to contribute to nursing education or nursing research in Canada.

What is a little lad?

He is a person who will continue what you have begun. When you are gone he will occupy the same seat that you now occupy and will work at the things that you think are important. You can adopt all the methods you please, but how they are realized will depend only on him. You may make agreements and sign contracts but it is he that will have to respect them. He will take your seat in the senate and your place on the Supreme Court bench. He will take your posts at the church, university, in corporations. All the work that you have done will be judged, and praised or condemned by him. Your renown and your fortune are in his hands. He will have control of your cities.

At present, a future prime minister of Canada is playing marbles, and the most celebrated actor of his century is unhappy because he does not want to go to bed. It is not your contemporaries nor your fellow citizens, but the little lads who are playing in the school yard, who will say what you were — a great hero or a big talker. These little lads will amend your laws and laugh at your mistakes. They will think charitably of you, saying that you did your best or they will not. Be careful!

All your efforts are for them and the future of the nation and humanity is in their hands.

Don't you think that a little lad needs a little of your attention?

—*Echo*, Erie County Sportsmen's League

NURSING PROFILES

Helen Preston Glass began her duties as educational secretary of the Manitoba Association of Registered Nurses in August. A graduate of the Royal Victoria Hospital, Montreal, Mrs. Glass obtained a certificate in teaching and supervision from the University of Manitoba. Later, she completed requirements for the degrees of Bachelor of Science and Master of Arts from Teachers College, Columbia University where she majored in teaching medical and surgical nursing in a baccalaureate program.

Her nursing career has included general duty and private nursing in Alberta and British Columbia; clinical instruction in Prince Albert, Saskatchewan, and Vancouver; general teaching duties in Victoria General Hospital, Winnipeg and nursing supervision in the anesthetic department of the Royal Victoria Hospital, Montreal. As educational secretary, Mrs. Glass, as part of her duties, will give leadership in planning programs, institutes and conferences for registered nurses; provide liaison with the Manitoba Student Nurses' Association and the Emergency Measures Organization; assist in recruitment programs for schools of nursing.

Mrs. Glass is a member of Pi Lambda Theta and Kappa Delta Pi honorary societies.

Catherine Golightly Curry has joined the staff of the Registered Nurses' Association of British Columbia as professional secretary. Mrs. Curry graduated from the Municipal Hospital, High River, Alta. and obtained a diploma in teaching and supervision from the School for Graduate Nurses, McGill University in 1948.

Supervisory duties at the Vancouver General Hospital were interrupted for wartime service with the RCAMC. Following her army discharge in 1946, Mrs. Curry joined the staff of Shaughnessy Military Hospital where she worked as a supervisor until her marriage in 1951.

This month it is our pleasure to offer congratulations and good wishes to **Bertha Isobel Cameron,** the new director of nursing of the Montreal Neurological Institute. Her appointment will be of special interest to the hundreds of nurses — student and graduate — who have come to know her throughout her many years of service at the "MNI." Born in lovely Sunnybrae,



BERTHA CAMERON

Pictou County, N.S., Miss Cameron obtained her basic education there and her teacher training in the Provincial Normal College of Nova Scotia. Her decision to enter the nursing field followed after four years of general teaching experience. She is a graduate of the Royal Victoria Hospital, Montreal.

Very soon after graduation Miss Cameron was asked to accept the position of assistant supervisor, Ross Memorial Pavilion, R.V.H. In 1933 she became head nurse of one of the busiest surgical wards in the hospital. There she came in close contact with the neurosurgeons who, within a short time, were to direct the activities of the new neurosurgical unit. In October 1934 she became the first night supervisor of the Institute. In 1938, she joined the day staff as assistant supervisor of nursing. In 1950, following reorganization of positions, her title became assistant director of nursing. During the years 1938-45, Miss Cameron combined administrative duties with teaching responsibilities and many will recall gratefully their introduction under her guidance to this fascinating but exacting nursing specialty. By 1945 the work of the unit had expanded to such an extent that a clinical instructor was appointed to carry the teaching load.

Miss Cameron's quiet professional efficiency, administrative ability and personal charm are outstanding characteristics. Under her direction, the nursing department of the Institute remains assured of capable leader-

ship. As additional preparation for her duties, she recently visited a number of hospitals in Canada and the United States.

It is always of interest to know what the busy nurse chooses as a hobby. Miss Cameron's greatest pleasure off-duty is painting, both in oils and water colors — her favorite subjects — landscapes and still life.

Beatrice Elizabeth Stucker is zone supervisor of nursing with Indian and Northern Health Services for the southern Alberta region. A graduate of the Montreal General Hospital in 1953 and of the School for Graduate Nurses, McGill University, where she obtained her bachelor's degree in nursing, majoring in administration and supervision, Miss Stucker worked with the Victorian Order of Nurses 1956-59. Her first assignment with I.N.H.S. was as a staff nurse on duty at Fort Norman nursing station, N.W.T., 1957-60.



(Lane Studio, Calgary)

BEATRICE STUCKER

She is chairman of the Membership Committee of the Alberta Public Health Association and the representative of the public health nurses to the AARN for the coming year.

Marie-Paule Beaulieu was recently appointed nurse in charge of the Mobile Information Service with the Montreal division of the Canadian Cancer Society. Miss Beaulieu was born in Montreal and received her early education at a school conducted by the Soeurs Grises of Rimouski. Later she studied in Stadacona, Que. and at the Collège Ville-Marie in Montreal. More recently she



(Nakash, Montreal)

MARIE-PAULE BEAULIEU

attended the University of Detroit where she worked towards a bachelor's degree in philosophy.

Miss Beaulieu is a graduate of St. Justine's Hospital, Montreal. While living in Detroit she served for three years as assistant head nurse at Highland Park Hospital and for several years, 1944-51, as an occupational health nurse with American Metal Products. Her career has taken her far afield. She was on the staff of the American Hospital in Paris for a time and also worked in hospitals in Florida and California.

She was a member of L'Alliance française, Detroit and of an Italian cultural group in the same city. Golf, tennis and bowling are favorite sports.

When the Montreal Neurological Institute opened its doors in 1934, the direction of of its nursing services was placed in the hands of **Eileen C. Flanagan.** Since that time hundreds of nurses, both student and graduate, have come under her supervision as they have taken advantage of the specialized training in nursing care offered by the Institute or have joined the permanent staff. This summer, after a record 27 years of service, Miss Flanagan's retirement was annnounced. Nurses across Canada and elsewhere will join in offering sincere good wishes for her future happiness. Her career has been a singularly active one and, undoubtedly, will remain so as a greater measure of freedom provides the opportunity for professional and other interests.



(Zarov Studio, Montreal)

EILEEN FLANAGAN

Born in Quebec, Miss Flanagan is a graduate of the Royal Victoria Hospital, Montreal. To her nurse's training she later added a Bachelor of Arts degree from McGill University and a diploma in nursing education and administration from the McGill School for Graduate Nurses where she studied as the recipient of a research scholarship awarded by the late Dr. Charles F. Martin, former dean of the McGill Medical School. A year's observation in British hospitals plus study in administration at the Royal College of Nursing rounded out her professional preparation. Service as a head nurse, medical supervisor and instructor filled the intervening years prior to her acceptance of the position from which she has now retired.

Keenly and actively interested in professional affairs, Miss Flanagan has served as president of the Association of Nurses of the Province of Quebec, 1940-47; chairman of the CNA Committee on Legislation 1942-46; co-chairman of the committees on labor relations and legislation, ANPQ. Since 1958 she has been associated with the work of the provincial committee on hospital insurance. A past president of the Alumnae Association R.V.H. and of the Montreal Business and Professional Women's Club, she maintains an interest in both organizations and in her favorite hobbies of travelling and reading.

The Order of St. John has released the names of several nurses who will be honored by His Excellency Major General Georges P. Vanier at the annual investiture at Government House in November. They are: Miss EDITH HUDSON, Winnipeg, promoted to Dame of Grace; Miss A. J. ATTRILL, Winnipeg; Miss EDNA DOWNIE, Kentville, N.S.; Mrs. M. HOLLOWAY, Vancouver; Mme RITA ST. PIERRE, Rimouski, P.Q.

It has also been announced that MARGARET BESWETHERICK, a former St. John cadet, has enrolled at McGill School for Graduate Nurses this year in the degree program for graduate nurses. She was the recipient of a special award from the Countess Mountbatten Bursary fund.

Recently, the supply of Canadian-trained nurses has been totally inadequate to meet the demand. In 1944, the number of new graduates of Canadian nursing schools was 41 per cent of the total number of graduate nurses employed in Canadian hospitals. By 1957 the percentage had fallen to 19.

Hospitals have relied heavily on foreign-trained nurses. There is good reason to believe, however, that the supply of nurses from abroad will diminish. Per capita income is presently increasing at a more rapid rate in Western Europe than in Canada. As Canadian salaries become relatively less attractive, fewer nurses will emigrate to this country. And as the supply of immigrants decreases, it will be necessary to train more nurses in Canada.

An increase in nurses' salaries would be the most effective means of overcoming the shortage. It would enlarge the supply of nurses by encouraging more girls to enter the profession and probably, more important, by attracting married nurses back into the profession. An increase in salaries would, at the same time, reduce the demand for nurses by encouraging the substitution of other types of labor wherever nurses have been performing duties that do not require professional training.

—*RNAO News Bulletin*, Vol. 17, No. 3

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It isn't easy for a doctor to diagnose and treat a patient to whom he is a total stranger. Persons moving into a new area should make a point of choosing a physician and arranging for a medical checkup.

* * *

Change is not made without inconvenience, even from worse to better.—RICHARD HOOKER

In Memoriam

Mrs. Isabel Brown, a Manitoba nurse, died in May, 1961.

* * *

Agnes Campbell, a graduate of Winnipeg General Hospital in 1927, died this past summer in Winnipeg. She was on the staff of the Saskatchewan Anti-tuberculosis League for a period of 28 years until her retirement in 1955 due to ill-health.

* * *

Catherine Florence Chambers, a 1933 graduate of the Ontario Hospital, Toronto, died on August 13, 1961.

* * *

Zeta Alice Jane Clark who graduated from the Royal Jubilee Hospital, Victoria died in Vancouver on August 26, 1961. She served as a nursing sister in both the British and Canadian armies during World War I.

* * *

Margaret Olivia Cogswell who graduated from the Royal Victoria Hospital, Montreal in 1937 died on August 24, 1961 in Alberta as the result of an accident. Following her graduation from the School for Graduate Nurses, McGill University she joined the staff of the Royal Alexandra Hospital, Edmonton. Later she was appointed assistant superintendent of nurses, Aberhart Sanatorium, Edmonton and eventually became assistant professor of health, University of Alberta. Illness forced her retirement from this last position. She was a former advisor to schools of nursing in Alberta.

* * *

Violet Ruth Edmonson who graduated from Victoria General Hospital, Winnipeg in 1928, died on September 1, 1961. Following her nurse's training, she studied medical technology and became a registered medical technician. Later she joined the staff of the Department of Anatomy, University of Manitoba where she remained until her death.

* * *

Elizabeth (Matthews) Forbes, a 1950 graduate of Memorial Hospital, St. Thomas, Ont., died December 19, 1960. At the time of her death, she was a staff member of the Simcoe General Hospital, Ont.

* * *

Juliette Guillemette, a 1960 graduate of Hotel Dieu Hospital, Alma, P.Q. died in July 1961 after a short illness.

* * *

Lucy E. Junod, a 1927 graduate of the Winnipeg General Hospital died April 7, 1961, while visiting in Geneva. She served as a nursing missionary for four years in Tanganyika and for almost 14 years in French Equatorial Africa and the Belgian Congo. Upon her return to Winnipeg she engaged in private nursing.

* * *

May A. Horne, a Toronto nurse, died suddenly in August, 1961.

* * *

Esther Muriel Kitto, a 1945 graduate of the General Hospital, Guelph, Ont. died in Toronto on July 22, 1961.

* * *

Annie (Wallace) Mathewson who graduated from the Royal Victoria Hospital, Montreal in 1923 died during August 1961.

* * *

Leanore M. (Fitton) Parker who graduated from St. Michael's Hospital, Toronto in 1936, died on August 8, 1961. Her professional life was spent in private nursing.

* * *

Helen Reid who graduated from the Royal Victoria Hospital, Montreal in 1932, died in Fredericton, N.B. on August 2, 1961.

* * *

Sister Margaret O'Grady, a member of the Grey Nuns of Montreal and a graduate of St. Boniface Hospital, Man. in 1916 died on March 16, 1961 in Edmonton. During her professional life she served as director of the school of nursing, Regina Grey Nuns' Hospital; superior of St. Paul's Hospital, Saskatoon; superior-administrator of St. Vincent's Hospital, Toledo, Ohio; and in an administrative capacity at the Edmonton General Hospital.

* * *

Sister Mary Patricia (Antoinette Coughlin) who graduated from St. Joseph's Hospital, London, Ont. in 1923, died during 1960.

* * *

Aline (Lawrence) Smithson who graduated in 1924 from St. Joseph's Hospital, Victoria, died recently.

* * *

Eva Alice Speechley who graduated from the Ontario Hospital, Whitby in 1931 died during 1961. She had devoted her professional career to institutional nursing.

* * *

Margaret Spitzig, a 1918 graduate of St. Joseph's Hospital, Guelph, Ont., died on August 23, 1961. She had engaged in institutional nursing.

CARDIAC ARREST

LLOYD M. HAMPSON, M.D., *and* S. VERA TEMPLE

Hannah Greener, aged 15, of Winlaton in County Durham, England, died under chloroform anesthesia on January 28, 1848. Thus, roughly 10 weeks after its introduction to the medical world on November 4, 1847, this first death under anesthesia was recorded. Hannah had received light chloroform anesthesia while in a sitting position. The operation was to have been the removal of an ingrowing toenail.

Anesthesia Fatalities

IT WAS NOT UNTIL 1874 that experiments on massage of the hearts of laboratory animals were described. In 1889, the first attempt was made to massage a human heart but it was as recently as 1900 that the first partial success was reported. In this century, interest quickened. Co-incident with the investigation of ventricular fibrillation and the clarification of its causation and treatment, it became possible to attack the problem of anesthetic fatalities.

Dr. Claude S. Beck, who initiated so much of practical importance in this field, recorded the first successful case of defibrillation of the human heart by electric shock in 1947. Thus, it took exactly 100 years after the introduction of chloroform to progress to this stage. In 1950, the first course in the practical management of cardiac arrest was instituted by the Cleveland Area Heart Society, Cleveland, Ohio.

Causes of Arrest

Of all the organs the heart is probably the most remarkable. All of its parts have the property of initiating and spreading impulses. Hearts, perfectly isolated from cold-blooded species, will beat for days. The beat can be restored in refrigerated rabbits' hearts after 44 hours. Dr. Robert M. Hosler, Cleveland, was successful in restoring the heart beat in a three-months-old infant for one hour, 24 hours after death. It is evident that given the opportunity, the human heart will beat. Why then does a heart stop during an operation under anesthesia — the worst possible moment, according to the anesthetist?

The list of factors in cardiac arrest is a long one. It changes according to anesthetic agents and techniques. At one time fear could be said to head the list. In the past the causative relationship of **fear** could not be appreciated since no study had been made of the effects on the heart of an outpouring of adrenalin into the circulation. Now we know that an agent like chloroform is lethal in such a situation.

> Even though its significance was not recognized, some such fact often crept into the case report in all innocence. For example, in one case a man was to be anesthetized for an amputation of a toe. After half an ounce of chloroform had been used, he was still not under. The whole supply was then exhausted and more had to be sent for. The unfortunate man was kept waiting on the operating table for more than two hours before the second attempt was made. He then died like a shot rabbit in a few seconds. Just imagine his feelings during the apparently endless delay![1]

Even with today's agents, when an anesthetist who is making a preoperative visit detects worry to an unusual extent, special efforts are made to combat it. Barbiturates, the tranquilizer group of drugs, and heavy sedatives are all used for this purpose. *If the patient once admits to fear of impending death, the operation should be cancelled forthwith.* Anesthetists have an aphorism, "If the patient says he's going to die, he will." Accordingly, if an attending nurse hears a patient talking in this vein, it should be treated very seriously and brought to the attention of the anesthetist without delay.

Most causes of cardiac arrest seem to be connected in some way with a breakdown in the transport of oxygen to the heart. Causes may run from the obvious ones, such as a fault in

the anesthetic mixture, to others less easy to recognize. Chronic anemia and undernourishment in old people or in patients with long-standing cancer or intestinal obstruction are just as frequent reasons for having the patient under-oxygenated due to failure of the blood to transport oxygen. Preoperative correction of these factors by blood transfusion to ensure a full hemoglobin and blood volume level is very important.

Much has been written about the effect on the heart of **reflexes** set up during the operation by traction on abdominal organs. The anesthetist tries to prevent the spread of these reflexes by making sure that the patient had at least 0.4 mgm. of either atropine or scopolamine preoperatively. If, during the operation, a slowing of the heart rate is noted, additional amounts of atropine are given intravenously to counteract the effect of the reflexes and to prevent inadequate coronary filling produced by a slow heart rate and falling blood pressure. It has been said that a heart under anesthesia is as vulnerable to vagal stimulation as a heart with a diffuse organic lesion would be without anesthesia.

There are many factors that may be at the root of the problem in an instance of cardiac arrest. Often things, insignificant in themselves, may be compounded by other individually insignificant effects.

Treatment

What can be done once a surgical team is confronted by a cardiac arrest? This emergency calls for the most concerted and instant teamwork of any surgical situation. Once circulation to the brain halts, there is an interval of only three to five minutes to get oxygenated blood back to it. There is no time for anything but decisive action as often no one in the operating room is quite sure of the exact time of cardiac arrest. It might be that the end of the time limit had already been reached when the arrest was diagnosed.

Of paramount importance is the resumption of circulation. Opening the chest to permit manual massage of the heart is, at present, the only effective treatment. Every other measure undertaken is related to this one act.

Hospitals are more prepared for cardiac arrest than ever before. A sterile cardiac arrest tray, wrapped in a red cover (the only red-wrapped tray in the operating rooms) is located in all operating areas in our hospital. Equipment is also in readiness for intubation of the trachea and attachment to an anesthetic machine by which the lungs can be inflated with 100 per cent oxygen. Complete familiarity with the steps of the routine to be followed when cardiac arrest occurs is highly desirable.

The following steps must evolve as a continuous pattern:

1. Thoracotomy by the surgeon;
2. intubation and insufflation of the lungs with oxygen by the anesthetist;
3. positioning in Trendelenburg by the nurse.

The Nurse

Naturally, there are a number of actions involved in carrying out these procedures, but so important is speed that the nurse must keep in mind what *not* to do in order to avoid delay.

She must not prepare the skin,
She must not drape,
She must not provide gloves,
She must not provide drugs for injection.

The Doctors

There are also *don'ts* for the surgeon and anesthetist:

Do not give an intravenous infusion
do not give an intra-arterial blood transfusion
do not dilate the rectal sphincter
do not make an abdominal incision for subdiaphragmatic massage
do not give intracardiac drugs
do not give more than one thump on the chest prior to thoracotomy
do not waste time with blood pressure. If there is no pulsation in large vessels such as the aorta, the diagnosis is made.

Restoration of Beat

The surgeon institutes cardiac massage without even pausing to open the pericardium. Since the lungs are being inflated with oxygen, there ought to be an effective circulation of oxygenated blood. The time has come to establish a normal heart beat. Up to this point it is not known whether the heart is in "standstill" or in ventricular fibril-

lation. Since the procedure for resuscitation is entirely different in the two conditions, the surgeon stops massage momentarily and observes the ventricles. If there are no fibrillary movements he can assume that the heart is in standstill or asystole. He will be helped in differentiating by opening the pericardium for direct observation of the heart surface.

Restoration of the heart beat in standstill may be unbelievably easy. The normal heart will beat if given the chance. If it does not beat unaided, other measures may be necessary. Three to five cc. of 1:10,000 epinephrine solution is injected into the chamber of the right ventricle and massage is continued. In many instances the heart will then begin to beat, if all conditions are favorable. If after three to five minutes of adequate massage there is still no heart beat, epinephrine may be injected for a second or a third time. At this stage a mechanical respirator may be attached to provide optimal aeration of the lungs. The Bird assister-controller, similar to the Bird ventilators used to assist respiration in many other cases, is such a machine. Hosler says:

> Inadequate oxygenation of the blood and inadequate elimination of carbon dioxide are the common causes of failure to restore the heart beat.[2]

In ventricular fibrillation the heart muscle is in a state of ineffective movement of muscle bundles. All movement must be abolished in order for a normal beat to be initiated. To do this, an electrical defibrillator is necessary. Until the defibrillator is available, cardiac massage is carried out to overcome the dilatation and anoxia of the heart and to ensure good color and tone of the heart muscle. The defibrillator is an instrument for delivering an electrical current to the heart which produces coordinated contraction of all heart muscle fibres. When the current is broken, the fibres all relax together. It is hoped that the atrio-ventricular node will send down the stimulus that will result in a coordinated beat. Often the heart remains motionless for seconds, then suddenly there is a forceful beat — almost like a large gulp.

Failure to produce a coordinated beat means a resumption of fibrillation and the shock procedure may be repeated. If the shock is given several times without success, 3-5 cc. of 1 per cent procaine is injected into the chamber of the right ventricle. At this point, the use of procaine often means the difference between success and failure.

Several types of results may be obtained from cardiac resuscitation:

1. Full recovery of cerebral function, of respiration and heart beat. This is the ideal result and the one that is hoped for.
2. Full recovery of respiration and heart beat with delayed but eventual recovery of cerebral function. Cerebral edema from the anoxic incident is undoubtedly the reason for the delay in recovery of cerebral function.
3. Full recovery of respiration and heart beat but permanent impairment of cerebral function.
4. Lesser degrees of success may occur but these patients usually do not survive.

As a result of continued efforts, more and more completely successful results of cardiac resuscitation are being reported in medical literature. This is a field in which one may expect to see many changes in the future, as continued dissatisfaction brings forth new ideas. Any occurrence which appears in the order of once in every 2,000-5,000 anesthesias, rates our every effort to produce successful answers either for prevention or for treatment.

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2. Hosler, Robert M. *A Manual on Cardiac Resuscitation.* Springfield, Ill.: Charles C. Thomas. 1954.

I believe that man is here for the purpose of realizing as much as possible of his desirable potentialities within a stable and yet elastic society. — ALDOUS HUXLEY

Culture: the acquainting ourselves with the best that has been known and said in the world, and thus with the history of the human spirit. — MATTHEW ARNOLD

ADMINISTRATION and the Changing Role of the Nurse

C. A. MEILICKE

Hospital administrators and their nursing associates should never forget that they are interdependent; that they are striving to achieve the same ultimate goals.

THE INTEREST OF THE hospital administrator in nursing is not the result of a niggling tendency to meddle. Rather, it arises from a deep-seated interest in patient care and all of the problems that surround it. Dr. R. W. Gabel summed it up quite nicely when he wrote in the journal of the American College of Hospital Administrators that:

> Hospital administration can not properly be anything but patient-centred. When hospital administration involves a manipulation of the patient to serve some other intermediate end, the purpose of hospital care is defeated.

Hospital administrators are interested in achieving the best possible patient care that can be given. As a result, they are interested in any problems that affect the personnel who are involved in providing either direct or indirect patient care. It is fair to say that the nursing profession is experiencing certain problems in adjusting to the changing demands that are being made for nursing services. First of all, these problems do not reflect, in any way, an inadequacy on the part of the nursing profession. It has been caught up by circumstances beyond its control that are forcing it to review its approach to the current situation and to what the future situation will be.

Any professional group is influenced by a variety of economic, sociologic and historic factors. The combined forces of these ever-changing pressures require the professional group continually to adapt its attitudes and techniques in order to maintain a stable and effective position in the light of current developments. In the past the nursing profession has responded to these pressures in a most laudable fashion. Its ability to adapt its role and its attitudes in the light of constantly changing demands for services has been a tremendous credit to both the leaders in the profession and the rank and file members who carry out the everyday tasks in hospitals all across the world. The requirements for change, however, are never ceasing. It is in regard to the modern demands for change in the nurse's role that these comments are directed. The area to be discussed is the place that administrative knowledge has in the nursing profession and the advantages to be gained by exposing members of that profession to a study of the theories and practices of administration.

A Changing Role

The gradual evolution of the nurse from a combined housekeeper, cook, laundry woman and dispenser of bedside care to the modern concept of a professional nurse, who is well trained in a variety of technical and scientific subjects as well as in the art of T.L.C., is probably only the preliminary stage in her development towards an even more specialized and complicated role. The significant factor in this increasing specialization and complexity is that nurses are being required to spend a greater amount of their time supervising, training and working with other personnel. There is probably some advantage in looking at the developments that are contributing to this change in the nurse's role. If we analyze them carefully it should be possible to discover what course of action can logically be taken. These developments, may be divided into two major groups, developments outside the nursing profession and those within the nursing profession itself.

External Developments

Physical developments in hospital

organization: The first, although not necessarily the most significant factor outside of the nursing profession, is that of the purely physical developments in the field of hospital organization. Hospitals are becoming larger. It is an obvious fact that the larger the size an institution achieves, the greater the number of people who are required to run it and the more links there are in the hierarchical chain.

Dr. Hugh McDonald recently stated in relation to the changing role of the nurse that "the vastness of our large institutions makes organization, coordination of services and communication skills an ever-increasing problem."[1] What he is saying, in essence, is that within the nursing department, there is a greater need for individuals who understand and appreciate the administrative disciplines because the increased division of nursing service into separate administrative units multiplies the number of supervisory personnel required. The lengthening chain of command, or the distance from the top to the bottom of the nursing department organizational chart, requires the appointment of more personnel to supervisory and administrative levels.

One must grant that this particular problem is not so severe in the small hospital. However, there are two significant factors that reduce the benefit — if one can call an escape from administrative responsibility a benefit— that accrues to the nursing personnel in small hospitals. There is frequently an acute shortage of nursing personnel. Consequently it often falls on the nurse to assume significant administrative responsibility over a disproportionately large number of non-professional personnel. In extreme cases the unfortunate nurse is saddled with responsibility for much more than simply nursing service. Undoubtedly, she must feel many times that she has been somewhat compromised, in view of the training that she has had, when she finds herself supervising the laboratory, the radiology service, the laundry, the dietary services, and so on. The second factor involves the future of the small hospital. Although this is looking *far* into the future, it is probably safe to predict that the small hospital will represent a gradually decreasing proportion of the total hospital bed complement in future years. The result will be that the small hospital will gradually provide a haven for fewer and fewer nurses.

Advances in the field of medical science and therapeutic methods: The tremendous advances that have been made in the field of medicine have also created pressures for change in the traditional nurse's role by causing her to spend more and more of her time dealing with more and more people. The fact that nursing personnel have become members of a large health team, a development that has resulted largely because modern medical science has advanced to the point where its methods and techniques are so varied that they can only be applied to any one patient by a large number of specialized personnel, has again made new demands on all nursing personnel for a knowledge of organizing, coordinating and communicating skills. There is a need for this knowledge not only at the supervisory and directorship level in the organization but also at lower levels. Followers are likely to follow more effectively if they understand the principles involved in the organization and coordination of an agency composed of a large number of people working in concert. Similarly, communication skills are a prime requisite at all levels of an organization. Even the general duty nurse is now faced with the prospect of communicating a greater amount of information to a greater number of people than was required of her a few years ago.

Modern treatment and care techniques have resulted in an accelerated recovery time; in a tremendously inflated cost of hospital care and in the adoption of many specialized services, procedures and techniques. These factors, combined with the chronic shortage of beds in many of our hospitals, have increased the pressure on nursing service for efficient and speedy operation while, at the same time, making it more difficult to attain. These new demands can only be met if the nursing profession acquires more knowledge of how efficient management can be achieved.

A Changing Social Philosophy: A changing attitude on the part of the

members of our society regarding the treatment they will accept from their employers and professional associates has also created pressure for change in the role of the nurse. The treatment that will be accepted by nursing service personnel today is a far cry from the highly authoritarian treatment that was considered acceptable in the hospital of a few years ago. Administrative and supervisory personnel must be keenly aware of the principles involved in what the students of administration call the "human relations approach."

The human relations approach involves *treating employees as individuals who have wants, desires and aspirations that must be fulfilled if they are to be completely effective in their jobs.* To ignore these principles, to adopt authoritarian and impersonal administrative techniques is to court failure, if not disaster. Worse still, to disregard the teachings of a human relations approach to management may mean acceptance of a very second-rate method of administration.

Factors Within

It can be seen that there are several influences at work within the profession that are slowly pushing the nurse upwards in the administrative heirarchy. She is moving away from the patient to positions of a supervisory and administrative nature.

One factor is the increasing shortage of nursing personnel. The shortage is not entirely an absolute one, that is, it is not entirely a reduction of the number of nurses available on a per bed basis. It has been caused partially by a reduction in the total hours of work that are provided by nursing personnel due to shorter working hours per week, and by a loss of nursing personnel to non-hospital positions. The effect has been an increase in the utilization of ancillary nursing personnel. The end result of this cause and effect relationship has been the creation of a situation in which more and more nurses are being promoted to positions in which they have supervisory authority over other individuals. The team leader position in a hospital utilizing the team nursing technique is an example of this.

Another factor is the increasing expense involved in retaining nursing personnel. The nursing profession, in its drive to improve the welfare of its members through the negotiation of improved salaries, hours of work, fringe benefits, and so on, is gradually pricing its services at a rate that is too costly for hospitals to pay. Again, the hospital has resorted to the utilization of non-professional nursing personnel and an increasing delegation of traditional nursing functions to ancillary services such as central supply, oxygen therapy and housekeeping. These circumstances have tended to force nurses into supervisory positions, and to draw them out of relatively solitary work situations into those in which they are dealing with a great number of ancillary personnel. The reason for the nurse's "promotion" into a supervisory position is that, rightly or wrongly, of all the personnel in nursing service, she is considered to be the best qualified as a supervisor. And yet, she has had little or no administrative training!

Summary

The increasing size of our hospitals, developments in the field of medical care and therapeutic methods, a changing social philosophy, a shortage of nursing personnel and increased costs of nursing services are combining to pull an increasing number of nurses away from the bedside and into supervisory and administrative roles. In addition, these factors are requiring all nurses to work with a larger number of people who have a variety of backgrounds and training. Nurses, as a consequence, are now faced with a work situation in which there is more emphasis on communication skills and organizational and coordinating ability than there was in the past. A logical question to ask, given these circumstances, is whether or not the administrative disciplines would be of any value to nurses in their new role. To determine this we must know what the administrative disciplines involve.

What is Administration?

Administration is simply getting things done through the efforts of others. Any subject that will assist an individual to achieve predetermined goals through the collective efforts of himself and a group is contributory

to administrative knowledge. Obviously, administration is not an exact science, nor a well-defined subject, but neither is the practice of administration an exact and rigid affair. It is, and must be, a flexible and fluid application of broad principles and general knowledge.

It is possible, however, to introduce some coherence into the picture of what one wants to study in order to assure a basic knowledge in the field of administration. The following categorization of the disciplines or topics involved is probably as satisfactory as any.

Functions and Principles of Management

The basic approach to a study of administration, whether it is for an individual at the lowest supervisory level in the organization or at the highest policy-making level, is a study of the functions and principles of management. These topics are what one might call the scientific basis of administration for they are founded on "a body of facts or truths systematically arranged which show the operation of general laws."[1]

One way of describing the functions of management is to reduce them to the mnemonic word POSDCoRB. It represents the first letters of planning, organizing, staffing, directing, coordinating, reporting and budgetting. The scholars of administrative science have produced a wealth of valuable material that analyzes and discusses the theory and practice of these functions. This material is a must for a person who will be involved in any aspect of applied administration and, as mentioned earlier, it is of significant value to those persons who are on the receiving end of the administrative process.

The principles of management are the fundamental truths that must be adhered to, albeit in a flexible manner, if administrative action is to be effective. Indeed, a knowledge of the principles of management is probably more important than a knowledge of the functions. Anyone who becomes involved in management is usually forced into various functions whether they are understood or not. However, the individual must know the principles for they do not readily make their presence felt and, if they are disregarded, administrative failure is imminent. There is little doubt that to ignore the need for equal responsibility and authority in a given position, to neglect to maintain centralized control of a given set of activities, to inadequately define policy in the light of objectives is to court disaster.

The Behavioral Sciences

The second major division of administrative disciplines is the behavioral sciences. In contrast to managerial functions and principles, which tend to be relatively definite statements, the behavioral sciences tend to be more tenuous and less definite. A study of these subjects, although procedures and techniques will be learned to a certain extent, will invest the student primarily with a set of attitudes and feelings that will influence his success in applying the scientific aspects of administrative knowledge to the practical situation. Because dealing with people is the very essence of supervisory and administrative jobs, and because it is a key factor in relationships at all levels of organization, it is fair to say that the study of these subjects will be of benefit to all personnel in the nursing department. This aspect of administrative knowledge might even assist the student nurse to provide better patient care because total care is only achieved when the patient is understood as a personality.

This understanding and the ability to meet personal needs through it will certainly be fostered by a knowledge of the behavioral sciences. They include sociology, psychology, anthropology and history. An appreciation of these subjects is essential to successful relationships with people. On the other hand, almost any intellectual activity that alerts an individual to the way in which people feel and react will be of assistance to him in administrative functions. Successful supervision, administration or just getting along with people will be accomplished most easily by a widely read person.

Summary

A study of administrative disciplines involves two major areas: The functions and principles of management,

which tend to be relatively tangible statements of procedural techniques; the behavioral sciences, less tangible subjects which introduce the student primarily to attitudes and beliefs that should deepen his insight into human personality.

Conclusion

If we may assume that members of the nursing profession would benefit from some degree of insight into administrative disciplines and that the principles of management and the behavioral sciences represent a general categorization of these disciplines, the question remains: how can this knowledge best be imparted to the members of the profession and how much detail must be covered? This is a problem for the nursing profession to solve. It has taken entirely commendable steps in this direction already. Some schools of nursing, for example, give instruction in team leadership. The diploma school at University Hospital, Saskatoon, offers students 10 hours of instruction and approximately three weeks of practical experience in this skill. The five-year training programs in teaching and supervision that are offered at many universities and the one-year postgraduate diploma course in administration of hospital nursing service, such as the one that is offered at the University of Saskatchewan, represent other excellent measures. Correspondence courses such as the program in administration for head nurses that is being offered by the Canadian Hospital Association and the Canadian Nurses' Association and the course in administration of small hospitals at the University of Saskatchewan will help to fulfil other needs.

Whether the amount of training that is being given to student nurses is adequate, particularly in view of the fact that many more future nurses may be expected to assume administrative roles than is presently the case, and whether the university and correspondence courses that are or will be available can adequately fulfil the needs of all nursing personnel is another question. Again the profession must decide on these matters.

Administration, supervision and dealing with people in general, is primarily an art that can only be mastered by practice and concentration. No matter what training an individual receives or how diligent a program of personal studies he pursues, success at the art of getting things done through others is still attendant on the individual's interest in improving his standard of performance. If the modern nurse is to maintain her position in the changing nursing scene, it is essential that she exert a continuing effort to improve her administrative talents.

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WHY STUDY THE HUMANITIES?

Education in the humanities is without any doubt a superb preparation for making a living and for attaining positions of importance and responsibility. However, perhaps the best reason for studying the humanities is not that they prepare a person for earning a living, but that they can prepare him for living a life. In studying the humanities, a person will develop himself. His knowledge will grow. But, more important than that, his mind and character will be enhanced by the experience. His understanding of people, including himself, of their thoughts and customs and environment, will be enlarged and deepened. It is this personal development, involving a better knowledge of man, which is the chief reward for a student of the humanities. As a result of it, he will be better equipped not only to do his job, but also to make good use of his leisure time. He will understand better the society in which he lives and will be more able to contribute to it.

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Professional Nurses' Associations and Good Public Relations

MARGARET E. KERR, M.A.

This address was given at the Public Relations Section of the ICN Congress in Melbourne, Australia, April 1961.

HOW OLD WERE YOU when you switched from grunts, squeals or cries to words to make your wants known? Your proud parents — your public — did not boast that you had "learned to communicate" but that was what had happened. As the months and years passed your "public" has steadily increased, numerically and in variety. Your ability to "communicate" has similarly expanded in every direction. In its simplest form, this is "public relations."

Public relations programs, as an adjunct to professional nursing plans and practices, are not a new thing though we have heard much more about them in the past ten years. More than a century ago, when the school of nursing in Bellevue Hospital, New York, was still in the planning stage, a member of the committee was asked how work would be found for graduates of the school. The reply presaged the launching of a whole new pattern of communication: "Our school will not train nurses only. We shall train the public at the same time."

Today, we are being bombarded by a veritable flood of articles on health topics, on hospital insurance plans, on the shortage of professional nurses. The general public is being so liberally peppered with pseudo-scientific information on the increase of lung cancer, the incidence of coronary thrombosis, the latest operative procedures and so forth, that the average housewife knows much more about medical care programs today than the average nurse knew 60 years ago. In fact, so much information is now available through newspapers, popular magazines, radio and television that there is a growing feeling that "the greatest barrier to adequate communication is the illusion that it has already been achieved."

When nurses talk about communication or "public relations," what do we mean? Why has the earlier word, "publicity," almost fallen into disuse? Why do we avoid using the word "propaganda" in reference to our programs? Actually, the basic meaning of all three expressions is the same. Put into simple phraseology, the various definitions seem to ask "Who is saying what to whom, through what channels and with what effect?" Most nurses' associations appear to have decided that "publicity" was not a sufficiently descriptive word; that "propaganda" carries the added connotation of a deliberate, sometimes forcible attempt to convert others to a particular ideology. Thus, we use the currently popular expressions "communication" or "public relations."

Our immediate goal here is to reach some agreement concerning four aspects of the topic. Who are the publics to whom our communications are going? Who prepares these messages? Where does the responsibility of the Professional Nurses' Association lie? How can results be measured?

The Publics (to whom)

Though there are millions of people in the world, there is no *single* public to whom any communication may be sent. Instead of being a collection of unrelated individuals, every community, from the largest city to the smallest hamlet is a fairly complex mosaic of interlocking social units. Excepting for the few who choose to live apart from human companionship, all of us belong to one or a dozen organizations. To a considerable degree, the groups to which an individual belongs will be determined and delimited by her educational standing, her economic status or her social level. Even the neighborhood in which she resides provides her

with a basic group. This affiliation with a group is the chief determining factor in shaping individual behavior and opinion. "What will the others think?" is the strongest single influence.

Within each group there is generally a key figure who sets the pattern of response and, ultimately, of behavior for her peers. Thus, while it may be difficult to reach and influence any significant portion of the population by a single communication, a great many people can be introduced to new ideas by these leaders. These gatekeepers of the channels of communication do not have any particular set of characteristics by which they may always be recognized. Nevertheless, it is always important to discover who they are and what is the best means to use in order to reach them.

Considerable research has been done into group reactions. These studies have demonstrated that this key leader and his group bring to every situation, to every new idea and to every change, the whole range of their personal values and needs. They will acquire new attitudes when they can be fitted into their past experiences and are useful in achieving some new purpose. A well-publicized immunization clinic, for example, may meet with a woefully limited response in a community, until such time as the key leaders have been thoroughly convinced of the need for or the value of the protection that is being offered, and in some fashion have indicated their approval.

Motivation plays an exceedingly important part in determining *what* people will perceive, as well as *how* they will interpret what they have perceived. The tendency for people to absorb only what they wish to absorb is illustrated by the fact that, even in nurses' conventions, the people who will attend the showing of films on topics that should be of intrinsic value and worth to every nurse are generally those who know most about the subject to start with.

We have noted that the major determinant in the degree of acceptance of public relations releases is the fact that individual opinion and response is shaped by membership in a group; that every group has key leaders who seem to be the strongest single influence in the group's acceptance or rejection of any communication. Those who accept are recognized as the believers, the co-operators, the "committed" persons in the community. Their early response is most important to the ultimate success of the program.

Resistance to various forms of public relations in nursing is seldom open or direct. Rather it is an uneasy and defensive conflict with infinite variations. Every group in the community has some image of nursing. This image may account for some of the resistance among the uncommitted who, if not openly hostile are probably apathetic to the messages. While they will be impressed by a communication from a source respected by their own leaders, they will not swallow a statement that is in conflict with their expectations from that source. For example, an endorsement of a beauty preparation by the president of the nurses' association would be completely out of character even though the president might be the most beautiful woman in the association.

The Message (what)

What is the "image of nursing" in the public mind? In its simplest form, the daily conversation between the nurse and her patient as a bed bath is being given may be the avenue along which a minor but non-the-less important segment of that image may be created. Individually and collectively, nurses every day have the opportunity to give substance to the nursing profession's claim that our primary objective is service to the public. *To hold and improve the trust of the public in that principle is the greatest single prerequisite in a public relations program.*

In order to achieve that purpose, the goal in public relations must be two-fold:

(a) To raise nurse-patient relationships to the highest possible level.

(b) To show that organized nursing is not a faceless, reactionary, selfishly-inspired business organization but rather that it is motivated by a sincere and abiding interest in the welfare of the public.

Oral communication — nurses speaking to patients, nurses meeting groups of patients in clinics or classes,

nurses addressing large audiences — is the most direct form for the messages to reach any part of the public. With such a widely diversified group as the tens of thousands of active nurses represent, it is inevitable that many of them will be almost as ill-informed regarding the goals of professional nursing as the public they are supposedly reaching. This calls for vital, lively, continuous programs of *internal* public relations, planned by the professional associations to reach every single member. It goes further. Special communications that will stimulate a growing interest in and appreciation of their chosen profession should be prepared for student nurses so that early in their careers they will learn and practise the kind of oral communication that the leaders in nursing consider of greatest value in the interests of good public relations. It is over-optimistic to expect the average applicant to a school of nursing to absorb the techniques of oral communication in nursing simply by being exposed to a flood of scientific data in the course of her regular classroom studies. She must be taught how to speak of professional matters.

Equally important in the adequate interpretation of nursing but far more difficult to reach than either the active graduate nurses or the student nurses are the vast numbers of "have beens" in every community. To their relatives and friends, often to a large sector of the public, these married and retired nurses are still fountainheads of information on countless aspects of professional activity. Alas! In so many instances they know less than nothing about the present-day developments in matters relating to nursing service, nursing education or the professional association itself. Many of them, unhappily, attempt to bluff the questioners rather than confess ignorance.

To reach all three of these groups of nurses with information that will create knowledge out of ignorance, transform hostility to approval, bring interest out of apathy, calls for thoughtful consideration and definite action by the professional nursing association. Through the various media at their disposal, the experiences of the many may be channeled to the individual, the efforts of the individual can contribute to the profession. A weekly or monthly professional journal, sponsored by the association, is the most logical form in which the printed word can be dispensed to the potential nurse readership. Every release from the association should be as carefully prepared as the scientific articles the publication contains. It requires the same degree of skill in the use of words as is devoted to releases that are intended for the general public. Frankly, unless the material from the association is vital, challenging and interesting, it will not be read.

What should the association include in these and any other of their releases aimed directly at their members? For so many nurses, the only contact with professional nursing organizations is through their local group. Their unmet needs may seem to overshadow the accomplishments and benefits of the association as a whole. In part, the image of professional activity that the average nurse hopes to see reflected in her professional association calls for a fuller, deeper understanding of policies and goals and of the steps that are being taken to reach those objectives. Between the announcement of a project and its fulfillment there are many gaps that lead to confusion. As a result, the membership seldom knows whether to hiss or to purr!

With an informed nursing public, *external* public relations will take on new meaning, new scope. The basic skill required is the ability to organize and express ideas — in either spoken or written form. The nurse speaker or writer is not called upon to present the elegance of a wit, a novelist or a poet. She must be able to express herself accurately, clearly, and in an orderly fashion but she does not need to denude her language of beauty and appeal. Her purpose is to communicate effectively. She needs to know how to write the right thing in the right way at the right time, in words that will adequately convey her meaning. This calls for careful thought and no little exercise of the imagination. She must try to form a mental picture of the specific audience she hopes to reach with her message. Then she will neither talk or write down to

her audience nor over their heads. A good piece of writing does three things:

1. It communicates a thought.
2. It conveys a feeling.
3. It gives the reader the impression that what he has just read was what he really believed all the time only he couldn't put his thoughts into words.

There are hundreds of cultural and physical influences which bear upon the behavior and reaction of readers. Any one message is only a small fraction of these influences. Consequently, there must be a continuous flow, a planned pattern of proceeding from one release to the next, a frequent change of pace in the style and form of the messages so that no reader will be able to say, "I know all about this. I've read it before."

Communication is an art and not a mechanical operation involving little, if any, skill or reflection. In many organizations and businesses, specially trained and qualified public relations personnel are employed on a full-time basis. Though this is a fairly expensive practice the many business organizations and some of the larger professional nursing associations have found that their public relations programs carry forward much more successfully when such experienced service is purchased.

The Responsibility

Before anyone can participate effectively in a public relations program she must believe in the truth and worth of what she writes and in the ability of the reader to receive and decode the message she is sending. No nurse should be chosen to head up such a program simply because she is attached to or lives close to the office of the nursing association. As much care should be exercised in selecting the chairman of the public relations committee as is given to the choice of the other major committees in the association. Essentially, the chairman and her committee have the task of generating interest that will lead to action. It may be a distinct handicap if well-informed people lose the sense of guilt they should have if they do nothing!

The national nursing association should make provision for instruction in public relations techniques for any of its constituent organizations requesting such assistance. This help may take the form of an institute or workshop on such topics as writing newspaper releases, preparing radio scripts, planning an immunization campaign, and so forth. As apparently simple a technique as devising interest-catching titles for public relations pieces could form a provocative lesson.

The title is the first thing the reader sees. If he does not like it, if he is not attracted by it, the probabilities are that he will not read the message that follows. If he does not read, then nothing has been gained by all the work that went into the preparation of the release.

It is important that titles should be concise, active, descriptive and meaningful. They usually emphasize a word or a phrase that conjures up a picture of the text. A couple of typical titles found on nursing releases will illustrate these points:

"A preliminary report on the present status of salaries and working conditions of nurses" could read, "Conditions move nurses . . . to Action!"

If "A new immunization clinic for poliomyelitis will be opened" read, "Diagnosis: Polio," it would attract a thousand more readers.

Professional organizations must be both bold and flexible in utilizing the media of public relations. The successes of the past were won because the leaders of that day saw clearly what they wished to accomplish, then set about enlisting public support. Their determination and vision, their unshakable belief in the cause they were promoting, coupled with an ability to speak and write words the public could understand has brought us, nationally and internationally, to our present position. It was not a magic formula that they had discovered. We, too, can march on to any heights we can discern or envisage if we too believe — fervently and honestly.

In all its public relations activities the association should abide corporately by the International Code of Ethics as assiduously as it expects its individual members to do so personally. It seems obvious that on a large number of topics of public interest it must

be the association that speaks out. By building a positive approach to problems of direct concern not only to the general public but equally to the individual members of the profession, when it becomes necessary to take any apparently negative attitude towards specific situations there will be understanding that the association's aim is truly constructive.

Measuring Results

How will the leaders in a professional nursing association be able to judge whether or not their public relations program is effective? It would be so convenient if there were only some mechanical yardstick with which precise, valid measurements could be made. Every communication is aimed at people, not at inanimate objects that can be broken into bits, weighed, measured or chemically analyzed. However, there are a few techniques that may be of assistance to those who are responsible for the planning, writing releases, and ultimately, assessing results:

1. *Pretesting:* Before any communication is put into general circulation its effectiveness with a small representative group will provide a clue as to its value. A message must produce a majority of satisfactory responses to the following questions if it is to be successful:

Attention and Interest: How many of the group were reached psychologically as well as physically by the message?

Motivation: For how many did the message offer a means of satisfying a want or achieving a purpose?

Pattern of Behavior: For how many will the action taken as a result of the message be in accord with the anticipated behavior?

Comprehension: How many understood the words, concepts and illustrations?

Understanding the Purpose: How many really understood the full import of the message?

Learning and Retention: How many actually acquired and retained the information?

2. *Popular demand:* Pamphlets, booklets or other releases that gather dust in the supply cupboard are not achieving any purpose. The association can measure the value of any particular piece by keeping a count of the number of requests for it. Experience has frequently demonstrated that people seem to place a higher valuation on a publicity piece if they have paid even a few pennies for it than if it is distributed free of charge.

Is there greater understanding of the professional association's reach towards new goals? Does a growing proportion of the association's membership echo the sentiment "I believe in the worth of this program?" When these are the responses there can be no doubt that good public relations are being achieved.

A new film, "External Cardiac Massage," describes the recently developed technique by which hearts that have stopped beating may be started again without opening the chest, exposing the heart and massaging it.

Produced in cooperation with the developers of the technique, the film demonstrates how the technique substitutes externally applied pressure for the rhythmic contractions of normal heart muscle, thereby maintaining circulation at a level sufficient to sustain life. Manual depression of the lower sternum, once per second, compresses the heart, forcing blood into the pulmonary and systemic vessels. Release of pressure allows the chest to expand and the heart to fill again.

"External Cardiac Massage" shows the steps to be taken to resuscitate patients when heart arrest or ventricular fibrillation occur, either within or outside the hospital. It also distinguishes between cardiac arrest and ventricular fibrillation, illustrates the use of the external fibrillator as part of the resuscitation technique, and demonstrates the application of the technique to infants and children.

The fourth in a series of medical teaching films for professional audiences only, the 21-minute, color and sound film is available on a free-loan basis from local representatives or directly from Smith Kline & French, 300 Laurentian Blvd., Montreal.

Others in the Medical Teaching Film Series, are "Resuscitation of the Newborn," "Human Gastric Function" and "Recognition and Management of Respiratory Acidosis." The films contain no product references.

THE HOSPITAL BED

MARCEL LANGLOIS, M.D.

The hospital bed has become the main link in the long chain of health services. Undoubtedly it has received the "freedom of the city."

ON THE BASIS of its own attributes the hospital bed has very minor appeal for us. We are interested in its general resistance to wear and tear; its construction; its comfort and whether or not it fits into the decor of the room but this interest is of a very impersonal, cold nature. However when we see the same bed in terms of the human being whose presence in it lends it life and purpose, how much more meaningful it becomes for us. This is the condition under which it achieves interest for all those concerned with health.

A few years ago doctors and nurses were the individuals most concerned in health matters. Today, this is no longer the case. The ranks of health workers have extended in all directions. Although it is generally accepted that medicine, nursing, pharmacy, biochemistry and hospital administration are pre-eminent, we cannot ignore the increasing contribution of other disciplines. Because of this vast number of interested organizations, one might almost say that the hospital bed has become the main link in the endless chain encircling the gigantic task of total health. To accept a challenge of the proportions implied by the latter, the medical and paramedical professions must seek the support of every contributing discipline. They do not have the right to isolate themselves and ignore the inevitable growth of the group involved in health.

To be truly realistic in its aims and effectual in action, each interested group must be aware of its own responsibilities and must be assured that its efforts are integrated with those of others. This implies integration of:

1. All medical specialties and nursing care;
2. special features of hospital administration;
3. relevant techniques;
4. all complementary services;
5. preventive services;
6. services related to mental and social rehabilitation;
7. the extensive group of private or state insurers;
8. the mechanisms of social security;
9. organized labor;
10. services of the armed forces.

Thus it can be seen that from the administrative standpoint, health is no longer the responsibility of a single government minister. The departments of social welfare and labor must also participate.

It is within this context, with its multiplicity of interdependent relationships, that the hospital bed must be considered. With so many possible facets of its role from which to choose, there are two that seem to stand out by virtue of their nature and the possibility of achieving some degree of synthesis between them.

1. The social and economic or political aspect.
2. The professional aspect.

Social and Economic Aspect

For a variety of reasons the hospital bed has been subjected to considerable social integration. This is readily understood if one considers the present universal demands on its services. There are very few individuals who, in the course of a lifetime, do not seek its help. It must be accessible:

To the rich and to the poor;
to the humble and to the proud;
to the cultured man and to the laborer;
to the newborn and to the elderly;
to the curable and to the incurable.

The social force of the hospital bed can be demonstrated even more clearly. It is acknowledged as:

The judge, the witness, if not the arbiter of the extent of social and economic contribution of which an individual is capable either before or after illness;

the instigator of all those forces responsible for the prevention of illness and the rehabilitation of the sick. It has

even on occasion been reproached for failing to make certain diagnostic or therapeutic services available. It must be remembered, however, that not every institution has the facilities to offer all specialized services;

the main source and inspiration of learning, not only in relation to medical science but in subjects of a social and economic nature;

the agent of an increasing number of social security and insurance bodies — whether adequately or inadequately remunerated is a matter of conjecture;

an institution obliged to make up for all the oversights of a society that fails to recognize all its shortcomings.

For the moment we are less concerned with the justification of function than in determining whether, economically, it can be assumed wholly or in part. Most certainly there is no lack of comparatively well-informed opinion at all social levels to assert and support their view that the hospital bed is responsible for its own impasse. Such an argument shows a lack of serious thought and is even indicative of ignorance. The only criticism that can be levelled against the hospital bed is that it has submitted rather blindly to the demands made upon it. It did not know how to resist at the proper time and place because it was so deeply imbued in altruistic principles. Unlike society, it has never denied the essential part of its calling, even though it has had to alter and adjust to modern social conditions.

Today, roles have changed. As the burden of illness has grown heavier, society has had to assume its share of responsibility, particularly on the economic level. This has been necessary so that the hospital bed could continue to symbolize *care for the ill* and not just *treatment of illness.* To achieve a less uneasy social status health workers must be convinced that this is an age of readjustment not revolution; that hospitalization is politic but not political; that the freedom of the patient will be exhibited more clearly in the adjustments made on his behalf than through the simple declaration of his requirements.

In relation to the economic position, a similar attitude must be adopted. Those in health work must be convinced that the economy of the hospital bed is based on justice, not charity; that the rising cost of medical and hospital services can be attributed, in large measure, to the negligence of a social and economic structure that has not foreseen the needs of the time; that the assertion that health services cost too much should be replaced by a much truer statement to the effect that the number who can perform them is steadily decreasing.

The Professional Aspect

Whatever one does, the professional nature of the hospital bed will always be the cynosure of praise as well as criticism. Upon it, all other aspects depend to a large extent. This supremacy stems mainly from the professional spirit of those involved in its services. This spirit takes precedence over scientific techniques and general efficiency. It is the very heart and soul of the hospital. The work of many craftsmen goes into its creation — the hospital administrator, doctors, nurses, pharmacists, biochemists, archivists, psychologists, dietitians and social workers.

United, the various disciplines can produce either a masterpiece or a curio. To produce a curio requires only that a free rein be given to individualism. To produce a masterpiece implies an appreciation of individual values and brings understanding professional consciousness into play. Team egoism becomes a sort of collective generosity whose power can override the impulses of individual self-seeking. No one can hope to be considered professional unless he is willing to accept the following criteria wholeheartedly:

Complete devotion of the resources of a stable personality; constant desire to improve oneself in human understanding; development of a largesse of spirit towards the weaknesses and peculiarities of mankind.

Obtaining a diploma is a necessary convention but it will never in itself develop a professional personality. The latter becomes the goal towards which one dedicates his time and energy. To the extent that it is unattained, we need not wonder at the loss of aggressiveness in overcoming difficulties.

The difficulties encountered are of two types — external and internal. In

the first instance, they are independent of the professional group and to a certain degree are imposed. The second group often arises without the individual's knowledge. One of the first external problems arises from ignorant or at least uninformed public opinion. The professional qualities are continually compared to that of any other service. To the general public, professional people in health work have become nothing more than anonymous distributors of a service. The hospital, and the professional people involved, will not overcome this current of opinion very easily if they depend only on pleas for leniency or pity. To restore their fortunes, regain prestige and meet the challenge they must note the demands of professional consciousness more carefully.

The list of external difficulties is far from exhausted but it seems preferable to stress some that are of an internal nature. Selection of these is hard since their causes or mechanisms spring from deep in human nature. The choice is made even more complicated by the professional interests involved. Depending upon the specific profession, the professional qualities of the hospital bed vary.

Professionalism and the Nurse

The professional nurse symbolizes one of the essential branches of the hospital tri-service. The other two are hospital administration and the medical profession. An attempt will be made here to bring into perspective what the nursing profession must *attain* in order to *maintain* its prestige intact and, hence, its professional character.

Can nursing preserve a professionalism worthy of the past on the highest ethical level or will it deteriorate to a mere caricature?

Even if administrative omissions, abuses, weaknesses or failures can explain some of the behavior of the nursing or the medical professions, should they be excused?

Should the nursing profession aim higher than the demands of general well-being? Should it not give preference to something of a more deeply vocational nature?

Is the nursing profession sufficiently adult to accept conditions of work and not limit the quality of its knowledge or service?

Will distrust and criticism sometimes levelled at the nurse by administration, doctors and patients alike not be more quickly stifled if complete devotion of her abilities accompanies her acceptance of work?

These are a few questions requiring thoughtful study. The theoretical replies to them are obvious but this is not enough. Our responses should have life and action. This is the price that the nursing profession must pay if it wishes to deserve and protect its professional nature.

The features of the hospital bed reflect the great human anxiety of the times. Whatever ones are considered the hospital bed is so generally accepted that it has exhausted any possibility of forgiveness. Inevitable errors are interpreted as bad intentions. The privilege of criticism must be respected but to be constructive it must be carried out in a spirit of kindliness and helpfulness. The hospital bed has never been considered to have a monopoly on all the virtues, the sciences, the arts.

Never perhaps in the history of mankind will the care and treatment of the sick be revealed as having been so extensive and so efficient as in our own era. In this respect the main purpose in existence of the hospital bed has never changed.

Its duties and the ones of those involved in health work have been carried out in such a way that only rarely do we see evidence of that inward uneasiness that has resulted in a dormant professional consciousness. Any attitude or behavior to the contrary could distort the human aspect.

The various facets of the hospital bed ultimately merge into one central purpose, the search for truth and the destiny of man.

God does not present Himself to us in completed form requiring nothing but acceptance but He is for us eternal discovery, eternal growth.

— Rev. Theillard de Chardin

The inevitability of gradualness. — Sidney Webb

Province-wide Bargaining for Nurses

EVELYN E. HOOD.

A new pattern of collective bargaining has been tried in British Columbia and shows promise of providing the vehicle for peaceful and orderly negotiations for working agreements.

THE EMPLOYMENT relations program of the Registered Nurses' Association of British Columbia was started in 1946 after a thorough study of collective bargaining and the mechanics by which the Association could bargain for its members. It was decided that the only effective method of achieving the aims of the Association in this field was to make use of the Labour Relations Act of the province and, on the request of the nurses, to apply for certification as the bargaining authority. The Association is now certified to bargain for the nurses employed by 46 hospitals, five health agencies and two industries.

The employment relations program has accomplished a great deal since its inception in 1946. The gains that have been made are not entirely economic. The program has brought increased understanding between the nurses and their employers. It has given nurses greater feeling of security to know that they now have a voice in planning the conditions under which they work and that grievances are carefully investigated and given serious consideration.

In recent years, it had become increasingly difficult to finalize agreements with some hospitals. The main causes were the tight budgets within which the hospitals operated and their inability to plan for future adjustments. As many as 21 disputes were referred to conciliation in one year. Both hospitals and nurses felt that a method should be sought to facilitate settlements. The RNABC asked the provincial government to establish some form of arbitration for final and binding awards. The government took no action on this request. The B.C. Hospitals' Association proposed province-wide bargaining as a method, not only of settling disputes but also of asserting autonomy in its relationship with the government.

In the fall of 1959, representatives of the Hospitals' Association asked for an opportunity to discuss a plan for provincial bargaining with the RNABC. The plan was outlined as follows:

1. Each Association would name a bargaining committee;
2. these two committees would endeavor to reach an agreement on certain terms of the nurses' agreements in hospitals where the Association had bargaining authority;
3. decisions of this joint committee would have to be ratified by the individual hospitals and the individual nursing staffs. There would continue to be separate agreements between the Association and each of the hospitals;
4. there would continue to be opportunity for individual staff representatives and the Director of Personnel Services of the RNABC to meet with representatives of the boards of each of the hospitals.

This plan was considered by the Council of the Registered Nurses' Association. It seemed to offer hope of avoiding the delays and stalemates of recent years. By unanimous decision, it was decided to recommend to the members that the Association participate in the plan, on the understanding that bargaining would be with a committee of the Hospitals' Association rather than with a professional negotiator and that the Registered Nurses' Association would be free to dissociate itself from the plan if it was found not to be in the best interests of the Association and the nurses concerned.

A committee appointed by the RN ABC met for two days, with a committee from the B.C. Hospitals' Association in November 1959. They agreed upon certain terms to be incorporated in new collective agreements. Agreement would be on the basis of recommendations to the hospitals and the nurses concerned. Before it became

effective in any hospital, individual contracts had to be completed, binding the hospital's board on the one hand and its nursing staff on the other. The terms of the agreement provided for a a two-year contract and a new salary scale, with larger differentials between positions. A medical care plan was included as well as the establishment of an employer-contributed pension plan. Unanimous acceptance of the proposals was achieved.

Since the inception of provincial bargaining in 1959, even the hospitals in British Columbia that do not have a formal contract with the RNABC have based their employment practices on the recommendations of the provincial bargaining committees. The years of bargaining on a *local* level with the give and take of direct negotiations had developed understanding and respect for each other's point of view, between agencies and nurses. This understanding has paved the way for *provincial* bargaining and has formed a firm foundation to build on for the future.

Book Reviews

Dr. Hans Selye's Famous Concept of Stress and Your Heart as explained by Fred Kerner. 237 pages. McClelland & Stewart Limited, 25 Hollinger Road, Toronto 16. 1961. Price $4.95.

Reviewed by Miss Dorothy Dent, 265 Daly Avenue, Ottawa.

Stress is a familiar word to all of us. Everyone at some point during his lifetime experiences it to a greater or lesser degree. Fred Kerner, in language understandable to all, brings out the relation of stress to heart disease and other illnesses in which it is a contributing factor. He shows that stress, in its proper place — controlled, directed and utilized — has a part to play in a progressive society. A minimum of it is basic to maintenance and preservation of life. Through its use a person can meet aggression with an adaptive defence mechanism.

The book is a directive for recognizing stress situations in various individuals. Stress to one person may be exhilaration to another. Stress can not be categorized as good or bad until it builds to the over-the-border degree, mentally or physically.

The book acts as a catharsis. You discover that you can not live without stress so you learn to live with it. A stress situation wedded to physical fatigue results in tensions, anxieties, conflicts, worries and frustrations with lack of coordination in thought and action. This must be avoided. To learn to forget is a great controller of stress. Forgetting our mistakes (we have all made them), our harsh words, (we have all said them) our unfulfilled hopes and desires (we have all had them), helps us to live a day at a time, more easily, successfully and productively. This book should be of great value to nurses and laymen alike. *Read it!* It offers a means of security against the trials of living that could only have been passed on to the writer by a great man truly interested in the human being as a whole personality.

Neurological and Neurosurgical Nursing by C. G. de Gutiérrez-Mahoney, M.D. and Esta Carini, R.N., Ph.D. 413 pages. The C. V. Mosby Company, St. Louis, Mo. 2nd ed. 1960. Price $6.50.

Reviewed by Miss Lillian Oatway, Clinical Instructor, University of Saskatchewan School of Nursing, Saskatoon.

This book has been revised to keep up with the progress being made in neurology and neuro-surgery and the ever-increasing need for expert nursing care in this area.

Definitions are clear and concise. Illustrations are plentiful. There is a detailed section on anatomy and physiology to be kept right at one's fingertips while dealing with the rest of the material.

Diagnostic studies, medical and surgical therapy for neurological conditions are outlined clearly and in good detail in separate chapters. They are then referred to specifically as the treatment and nursing care of each disorder is elaborated upon in its own unit. The reader, therefore, must be familiar with the format of the entire book in order to use it effectively.

There is some repetition in the chapter on "Diagnostic Study of the Patient" as a result of the manner in which it is set up. The chapter on "Medications most frequently used" requires additional references. It is surprising, also, that hypothermia is not mentioned among the therapies.

This publication is informative and easily read. It is an excellent reference book and should prove a valuable asset in a school of nursing library or a clinical instructor's office.

Management of Obstetric Difficulties by J. Robert Willson, M.D., M.S. 687 pages. The C. V. Mosby Company, St. Louis, Mo. 6th ed. 1961. Price $16.50.

Reviewed by Dr. Margaret Hutton, 202 - 10856 Whyte Avenue, Edmonton, Alta.

In the preface the author indicates that this edition of his text is designed as a reference book for practising obstetricians and those participating in graduate training for the specialty.

In the last few years the multi-disciplinary approach to obstetrical care has been and is being stressed as a very important facet in the planning of an effective program to reduce perinatal deaths. Consequently, this book should be utilized as a reference text by nurses enrolled in post-basic degree courses, especially those who are planning a career in public health and attending lectures in maternal health and welfare.

The practising public health nurse in her health unit accepts as part of her duties a portion of prenatal care. Since she frequently must be prepared to give clear and practical advice on certain aspects of antenatal care, she should find this book of practical help, especially the appropriate chapters on prenatal care and the complications of the prenatal period. The chapter on the newborn infant contains valuable information to complete the nurse's understanding of some of the complications in the perinatal period.

This is a well-written and well-planned text. The reader will find it easy to locate various topics.

The Family Handbook of Home Nursing and Medical Care by I. J. Rossman, M.D. and Doris R. Schwartz, R.N. 403 pages. Doubleday and Company Inc., 575 Madison Avenue, New York 22, N.Y. 1958. Price $4.95.

Reviewed by Miss Dorothy Dent, 265 Daly Avenue, Ottawa.

Reading this book for the first time from the point of view of a public health nurse I was concerned and failed to see its value or place in the nursing scene. Then, coming down from my "ivory tower" I re-read it and recognized its value as a reference book to homemakers, practical nurses and nurses' aides, but only under the guidance of a qualified person in the application of its contents. Realizing that the trend today is towards home care programs and self-reliance as a result of overcrowded hospitals, this book will serve a purpose.

In the discussions of certain illnesses of a serious nature the authors write in a way to allay anxiety or pessimism, so that the book should not tend to cause a neurosis in any reader. It was pleasing to find an element of public health running through it. The chapter dealing with neurological diseases is outdated. Intensive research has been going on in relation to these illnesses and great strides have been made in the past three years. This chapter could stand revision. The discussion of cancer is helpful for patients and the anxious members of the family alike.

The chapter, "You and Your Doctor," advises using your physician wisely by discussing all problems at length. Granted that this is an ideal patient-doctor relationship, nevertheless the specialization in medicine and the resultant shortage of physicians in general practice, make it unrealistic to assume that such time-consuming appointments can take place. The patient's anatomy is divided among so many doctors that it is sometimes difficult to ascertain which one has the biggest portion.

Chapter VII, "Illustrated Guide to Home Nursing Methods and Procedures," is especially good and should be helpful to everyone. Chapter XIV, "When You are Sick and Live Alone," is informative and interesting.

This book serves its purpose as reference material for the laity only.

Sixteen years of peace with Japan have transformed public attitudes toward its people. Today, for every Canadian who claims to dislike them, there are six who have a friendly feeling toward the people of Japan. On a national average, half the public is definitely friendly and about a third have no particular feeling one way or another.

It is a matter of record that in 1944, 41 per cent of the nation reported bitter antagonism toward the Japanese.

Interviewers for this Gallup Poll also found that the degree of education increases still more the ratios of friendliness to antagonisms. Among those with university background about 6 in 10 report a liking for the Japanese, compared to less than 1 in 10 who are definitely unfriendly. Among those with only public school education, the division of opinion is closer with about 4 in 10 feeling friendliness and about 1 in 10 disliking the Japanese.

— *The New Japan*, Aug.-Sept. 1961

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Smooth Out Those Tensions

Most of us, from time to time, build up tensions. These may stem from the nature of our work, from relations with our colleagues, or any number of other reasons. Generally such tensions within us are unavoidable; it is important that we find ways of smoothing them out, of eliminating them. Here are some suggestions:

Talk it out. Don't bottle it up. Confide your worry to some level-headed person you can trust. Talking things out helps to relieve your strain, helps you to see your worry in a clearer light, and often helps you to see what you can do about it.

Escape for a while. Sometimes it helps to lose yourself in a movie or a book or a game or a brief trip. Making yourself "stand there and suffer" is a form of self-punishment, not a way to solve a problem. It is perfectly realistic and healthy to escape punishment long enough to recover breath and balance. But be prepared to come back when you are more composed.

Work off your anger. While anger may give you a temporary sense of righteousness, or even of power, it will generally leave you feeling foolish and sorry in the end. Do something constructive with the pent-up energy. Pitch into some physical activity. Cooling off for a day or two will leave you much better prepared to handle your problem.

Give in occasionally. Stand your ground on what you know is right, but do it calmly and make allowance for the fact that you could turn out to be wrong. And even if you're right, it's easier on your system to give in once in a while. If you yield, you'll find that others will too.

Do something for others. You'll find this will take the steam out of your own worries and — even better — give you a fine feeling of having done well.

Take one thing at a time. For people under tension, an ordinary work load can sometimes seem unbearable. When that happens, remember that it's a temporary condition and that you can work your way out of it. The way to do this is to take a few of the most urgent tasks and do them, one at a time. Once you dispose of these, you'll be in the swing of things, and the rest of the tasks will go more easily. If you feel you can't tackle things this sensible way, reflect: Are you sure you aren't



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Shun the "superman" urge. Some people can get into a constant state of worry and anxiety because they think they are not achieving as much as they should. They try for perfection. This ideal is an open invitation to failure.

Go easy with your criticism. Some people expect too much of others, and then feel frustrated when the other person does not measure up. Instead of being critical about the other person's behavior, search out his good points and help him to develop them. This will give you both satisfaction.

— *The Teacher's Letter*

The old wood stove is still the chief means of cooking and heating in summer cottages and rural areas but this kind of stove often proves temperamental and balks at lighting. It is very dangerous to pour coal oil into it. Bits of wax paper or old milk cartons will help to start a fire; bits of stick dipped into coal oil and included in the kindling are also effective.

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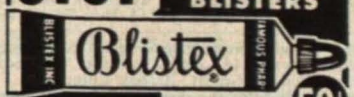
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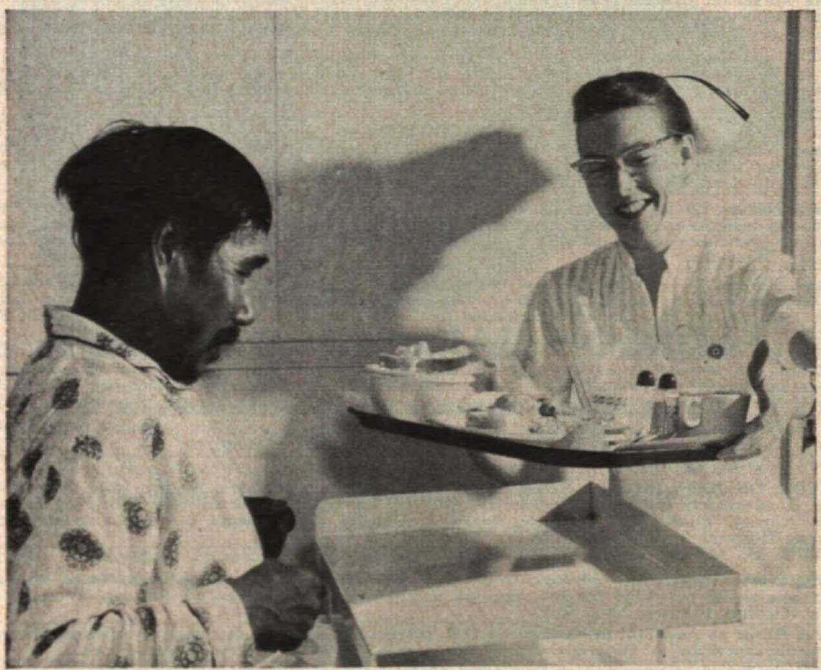
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For service to Indians across Canada, Eskimos and the population of the Yukon and Northwest Territories.

Those interested in positions at the following locations should write to: Fisher River Hospital, HODGSON, MAN.; Miller Bay Hospital, PRINCE RUPERT, B.C.; Moose Factory Hospital, MOOSE FACTORY, ONT.; Norway House Hospital, NORWAY HOUSE, MAN.; Sioux Lookout Hospital, SIOUX LOOKOUT, ONT.

Information on these and other I.N.H.S. positions is available from Indian and Northern Health Services, Department of National Health and Welfare, in Vancouver, Edmonton, Regina, Winnipeg, Ottawa and Quebec, or from the

Director, Personnel Services,

DEPARTMENT OF NATIONAL HEALTH AND WELFARE, OTTAWA

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Salary for B.C. Reg'd. Nurses $297 with regular increases; Unreg'd., $285. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 year. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $297 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurses for 20-bed hospital, 35-mi. from Vancouver, on Coast. Salary & personnel practices in accord with RNABC. Bus & train transportation, accommodation available. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

Graduate Nurses for General Duty (2) salary $297 per mo., charge for room, board & laundry $40 per mo. Graduate complement six(6), all statutory holidays paid, 28 days vacation after year's service, customary sick leave. Apply giving full particulars to: Matron, Slocan Community Hospital, New Denver, British Columbia.

Nurses (2) for 30-bed hospital. Salaries as per B.C. Registered Nurses' agreement. Comfortable nurses' home. Apply to: Miss H. Campbell, R.N., Director of Nursing, Community Hospital, Grand Forks, British Columbia.

MANITOBA

Registered Nurses (2 immediately) for 10-bed fully modern hospital. Salary $315 with increases of $5.00 following each 6-mo. service. $45 full maintenance, 40-hr. wk. Apply: M. Harness, Secretary, Benito Hospital Unit, Benito, Manitoba.

Registered Nurses (2) for 12-bed hospital in Lynn Lake, Manitoba. Salary $325 per mo. plus room & board. Group insurance, medical & hospital, pension plan available. 44-hr. wk., liberal holiday schedule. For further particulars, apply to: W. F. Clarke, Personnel Manager, Sherritt Gordon Mines Limited, Lynn Lake, Manitoba.

Registered Nurses (2) Licensed Practical Nurse (1) for 32-bed hospital, salary $295 and $210 respectively with $5.00 increases each Jan. & July., 40-hr. wk., 3-wk. vacation after 1 year service, statutory holidays, board & room $45 per mo. Uniforms laundered free. Apply to: Mrs. E. Sims, District Hospital, Roblin, Manitoba.

REGISTERED NURSES Positions available for General Staff Nurses at Clearwater Lake Hospital, The Pas. 150-beds for tuberculosis and extended treatment patients. Initial salary $310 per month. Good working conditions and excellent personnel policies. Accommodation in nurses' residence. Enquiries invited. Apply: Director of Nursing Services, Sanatorium Board of Manitoba, 1654 Portage Avenue, Winnipeg 12, Manitoba.

General Duty Nurses (3) for new 85-bed hospital. Good salary & generous personnel policies. Apply: Director of Nursing, Portage Hospital District #18, Portage La Prairie, Manitoba.

NORTHWEST TERRITORIES

DIRECTOR OF NURSING for 44-bed hospital in prosperous northern mining town. Hospital well equipped & adequately staffed. Expect to be ready for accreditation survey this Fall. Further information on request. Please send complete details of training & experience to: Administrator, Stanton Yellowknife Hospital, Yellowknife, N.W.T.

NOVA SCOTIA

Registered Nurses immediate opening; 1. **Evening Supervisor;** 2. **Operating Room Nurse,** 40-hr. wk., excellent salaries & personnel policies. For full details apply to: Director of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

Registered Nurse as Assistant to Head Nurse O.R. postgraduate course not essential, experience necessary. Apply stating experience to: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

General Duty Nurses (Immediately) **Registered Medical Record Librarian** (1) **Dietitian** (1) experienced **Operating Room Nurse** (1) for 75-bed hospital. Salary according to RNA of N.S. Comfortable living conditions. Apply: Superintendent, Highland View Hospital, Amherst, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses for modern 21-bed General Hospital on scenic Eastern Shore. Nova Scotia salary scale, 3-wk. annual vacation, sick leave, pension plan & 8 statutory holidays, good personnel policies, residence accommodations. Apply, giving name of training school, date of graduation & record of employment & experience to: Superintendent, Eastern Shore Memorial Hospital, Sheet Harbour, Nova Scotia.

Operating Room Nurse for 30-bed General Hospital situated on the beautiful South Shore of Nova Scotia. Good personnel policies & salary. Apply to: Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

ONTARIO

Assistant Director of Nursing Service, also Supervisor of in-service education program for January 1, 1962. Experience & postgraduate study desirable, good salary & personnel policies. Please apply: Director of Nursing Service, Hotel Dieu Hospital, Kingston, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax, Ontario on Highway 401, 20 mi. east of Toronto, hourly bus service to hospital. Salary in accordance with qualifications & experience, increments every 6 mo., sick & vacation time after 6 mo., sick time cumulative to 14 days, 37½-hr. work wk., pension plan, living-in accommodation. Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom,** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

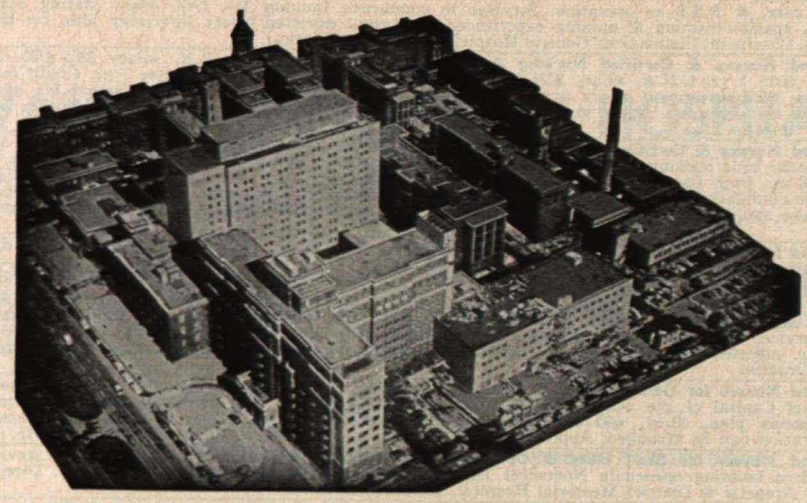
Registered Nurses $300 per mo. min. to max. $340, 3-weeks vacation with pay, sick leave after 6-mo. service. Non-Registered — $15 less, Cert. N.A. $210 min. to max. $240, 2-wks. vacation with pay, Non-Certified N.A. $200 to max. $230. Increases for both groups $10 per mo. after 1 yr. on staff. 9 statutory holidays. All staff:— 5-day 40-hr. wk. Apply: Superintendent, Englehart & District Hospital, Inc., Englehart, Ontario.

Registered Nurses for Psychiatric Nursing starting salary $270 with annual increases to $312, 5 day wk., residence accommodation, $36.50 per mo. Apply: Director of Nursing, Ontario Hospital, North Bay, Ontario.

REGISTERED NURSE with Operating Room experience for 106-bed General Hospital. Please apply stating qualifications & experience to the: Director of Nursing, Norfolk General Hospital, Simcoe, Ontario.

Registered Nurses, Certified Nursing Assistants for modern 75-bed hospital. Starting salary: R.N.'s $300 per mo. with merit increases after 6-mo. service, C.N.A.'s $216 per mo. Single room residence accommodation available. Attractive growing town of 5,500 mid-way between Winnipeg & Fort William on the main line of the C.P.R. on the Trans-Canada Highway in the midst of large tourist area. For information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing, District General Hospital, Dryden, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $300 & $210 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospitals of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.



TORONTO GENERAL HOSPITAL

REQUIRES

Registered Nurses and Certified Nursing Assistants
for Medical and Surgical Services
including newly opened Neurosurgical and Cardiovascular Units
Rewarding Experience — Excellent Personnel Policies

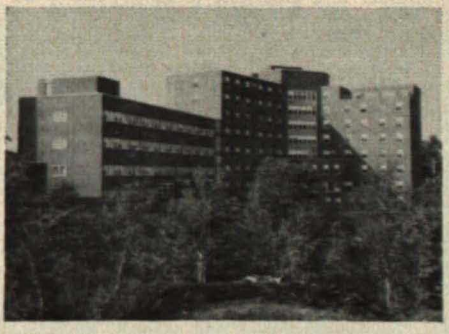
For information write to:

Director of Nursing, Toronto General Hospital, 101 College Street, Toronto 2, Ontario.

SUDBURY GENERAL HOSPITAL

of the

IMMACULATE HEART OF MARY



ON LAKE RAMSAY

Modern Hospital and School of Nursing

Active in-Service Program

Openings for Delivery Room and Operating Room Nurses

Apply:

DIRECTOR OF NURSING, SUDBURY GENERAL HOSPITAL, SUDBURY, ONTARIO.

Superintendent for ultra-modern, newly equipped 52-bed hospital, 40-hr. wk., 4-wk. vacation, pension, hospital care, & P.S.I. in operation. Services to commence January 1st, 1962. Apply stating academic standing, special training & nursing experience with salary expected before November 12th. to: Herbert Timmins, Chairman, Centre Grey General Hospital, Markdale, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $305-$352. 28-day vacation after 1 yr. C.N.A. salary $221-$252, 2-wk. vacation after 1 yr., 3-wk. after 2 yr. Credit for past experience, $5.00 increment every 6 mo., 40-hr. wk. 8 statutory holidays. Room & board $45 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses & Certified Nursing Assistants for 100-bed active General Hospital in Ottawa Valley. 45 additional beds opening late summer, 4 hrs. from Montreal, 2 hrs. from Ottawa, excellent train & bus service, 8 mi. from Camp Petawawa. Personnel policies include 5-day wk., 7 statutory holidays, 1¼-days sick leave cumulative to 60 days after 6 mo., 3-wks. vacation after 1 yr., employer participation in pension plan. Make application to: Miss E. Sheppard, Reg.N., Director of Nursing, Cottage Hospital, Pembroke, Ontario.

Registered Nurses for General Duty for smaller sized hospital, 40-hr. wk. Apply: Superintendent, Kemptville District Hospital, Kemptville, Ontario.

Reegistered Nurses for General Duty in modern 18-bed Private Hospital in iron mining town, 140 mi. north of Sault Ste. Marie, Ontario. Starting salary $290 min. to $330 max. for experience, less $20 per mo. for maintenance. Excellent accommodations & personnel policies, transportation allowance after 6-mo. service. **Operating Room Nurse** starting salary $310 min. with postgraduate course. $350 max. with 3-yr. experience or more. Apply: Superintendent of Nurses, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $285 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. All patients' services in new modern building opened in November 1960. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered General Duty Nurses (Immediately) for new, modern 35-bed hospital located in Almonte, 30-mi. from Ottawa. Good personnel policies. Apply to: The Director of Nurses, General Hospital, Almonte, Ontario.

Registered Staff Nurses for Operating Room Department; A new well-equipped unit; rotating hours of duty; attractive personnel policies. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $285, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $285 monthly, Graduates at $250; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for small active General Hospital, starting salary $285, excellent personnel policies, pension plan, residence accommodation. Apply: The Superintendent, Niagara Hospital, Niagara-on-the-Lake, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $285 per mo. with recognition for P.G. courses, 40-hr. wk. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south western Ontario, 32 mi. from London. Salary commensurate with experience & ability; $285 gross. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario.

General Duty Nurses for 350-bed General Hospital located in downtown Toronto — Rotating hours of duty, attractive personnel policies, in-service education program. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particulars, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

General Duty Nurses & Certified Nursing Assistant for modern 50-bed active hospital, 40-hr. wk. with all statutory holidays, pension plan & sick leave benefits. Meaford is situated on Georgian Bay & is an all-year resort town. For further information apply to: Director of Nursing Services, General Hospital, Meaford, Ontario.

Public Health Nurse for generalized program in the City of Belleville. Salary $3,600 - $4,600, 4-wk. vacation, P.S.I., pension plan, car allowance or transportation provided. Apply: Dr. McColl Metcalfe, M.O.H., 266 Pinnacle Street. Bellevile, Ontario.

Public Health Nurse (qualified) position open in a completely generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Box 1019, Bracebridge, Ontario.

Public Health Nurses required by Stormont, Dundas & Glengarry Health Unit for generalized program in Seaway Development Area, usual benefits, liberal car allowance, pension plan, allowance for experience. Apply to: Dr. Paul S. deGrosbois, Medical Officer of Health, Health Unit, 26 Pitt Street, Cornwall, Ontario.

Public Health Nurses—Minimum salary $3,500, allowance for experience up to 3 yrs., car allowance, pension plan, & other benefits. Personnel policies on request. Apply to: Dr. J. M. McGarry, M.O.H., St. Catharines-Lincoln Health Unit, St. Catharines, Ontario.

Public Health Nurses for generalized Public Health Nursing Service, Hospital P.S.I., pension plan, sick leave accumulative at the rate of 1½ days monthly, vacation 4-wk. per yr., car allowance, salary ceiling at present $4,300, initial salary dependent on experience. Apply to: Dr. I. T. Loudon, M.O.H. and Director, Norfolk County Health Unit, Box 247, Simcoe, Ontario.

Nurses (2) for United Church Mission Hospital in northern B.C. Salary: $305 per mo. An opportunity for Christian service. Apply: Wrinch Memorial Hospital, **Hazelton, British Columbia** or Dr. M. C. Macdonald, Board of Home Missions, United Church, 85 St. Clair Ave. East, **Toronto, Ontario.**

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

THE VANCOUVER GENERAL HOSPITAL

Appointments to nursing positions are available.

Good personnel policies in effect including medical welfare plan, 40 hour week — four weeks vacation. In-Staff Education program well established during winter months.

Salary $297 - $359 per month
with consideration for experience or special preparation.

Please apply to:

PERSONNEL DEPARTMENT,
10TH AVENUE AND HEATHER STREET,
VANCOUVER 9, BRITISH COLUMBIA.

JEWISH GENERAL HOSPITAL

MONTREAL QUE.



NURSING OPPORTUNITIES

In this modern 400-bed non-sectarian hospital in Administration, Teaching, Staff Nursing.

- Certified Nursing Assistants also required.
- Openings in all Clinical Services • Excellent personnel policies • Bursaries for post-basic courses in Teaching and Administration.

For further information, please write:
DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL, 3755 COTE ST. CATHERINE ROAD, MONTREAL, QUE.

Registered Nurses for 30-bed General Hospital, 50 mi. from centre of Montreal, excellent bus service. Starting salary $275 per mo., 3 semi-annual increases, 40-hr. wk., 4-wk. annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

General Duty Nurses for hospital for tuberculosis & other chest diseases. Situated in heart of Laurentian Mountains, 55-mi. from Montreal. 40-hr. wk., Equivalent to 12 statutory holidays per year, 4-wk. annual vacation, excellent salary plus full maintenance, including accommodation in modern nurses' residence. All winter sports, good personnel policies & working conditions. Apply: Director of Nursing, P.O. Box 1000, Ste. Agathe des Monts, Quebec.

Nurses wanted for new modern 100-bed hospital. For full information write to: Directress of Nursing, Saint Joseph Hospital, Maniwaki, Gatineau County, Quebec.

SASKATCHEWAN

OBSTETRICAL SUPERVISOR for 25-bed Obstetrical Unit. Qualified to teach student nurses. For further information apply to: Director of Nursing, Moose Jaw Union Hospital, Moose Jaw, Saskatchewan.

Registered Nurses for Fort Qu'Appelle Sanatorium. Initial salary: **General Duty** $300 per mo. **Charge Nurses** $315 per mo., with semi-annual increments. Recognition for experience. 40-hr. wk., 4 wks. paid annual vacation, 10 statutory holidays, sick benefit & superannuation plans in effect. Room, board & laundry $37.50 per mo. Apply: Superintendent of Nurses, Fort San, Saskatchewan.

Registered or Graduate General Duty Nurses for modern 25-bed hospital. Salary $290 - $380, 3 doctors on staff, 5-day 40-hr. wk., no split shifts, 3-wk. vacation after 1 yr. service, 9 statutory holidays, single rooms in modern nurses' residence with television, board & room $1.15 per day, laundry free. Established personnel policies. Apply by phone or write to: Mrs. Janie Sutherland, Supt. of Nurses, Union Hospital, Eston, Saskatchewan.

Registered General Duty Nurse for modern company hospital. Salary $315 plus full maintenance, additional allowance for postgraduate work. $25 increase after one year. Transportation paid from point of hire in exchange for one year service. Attractive holiday benefits, group insurance, recreational facilities. Apply to: The Hospital Matron, Gunnar Mining Limited, Gunnar, Saskatchewan.

Operating Room Nurse minimum starting salary $365, also **Registered Nurse** starting salary $330, for modern 26-bed hospital in northern Saskatchewan, consideration given for qualifications & previous experience. Complete maintenance at $45 in modern residence, 1-mo. annual vacation. Air transportation paid from Prince Albert or Edmonton. Apply to: Administrator, Municipal Hospital, Uranium City, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $350 with range to $390 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) **Staff Nurses for permanent positions,** various departments, days, eves, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $345 - $415, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurses immediate openings in most departments, well equipped 90-bed General Hospital located in the heart of Northern California recreational area. Good salary & fringe benefit program. Write: Personnel Department, Mercy Hospital, Redding, California.

REGISTERED NURSES modern new building, Santa Clara County Hospital. Many levels of nursing positions available. $373 entrance salary for Staff Nurses maximum $455. $20 differential for evening & night shifts. JCAH accredited teaching hospital for interns, residents, students, & registered nurses. 5 day, 40-hr. wk., social security & retirement plan, paid health plan, 2 wks., vacation yearly, 12 sick days yearly. First papers for citizenship essential & eligibility for California registration as a nurse required. For further information write to: Director of Nursing, Santa Clara County Hospital, San Jose, California.

Registered Nurse (immediate position on staff) for new 150-bed hospital. Immediate California registration available. Write: Director of Nursing, Little Company of Mary Hospital, Torrance, California.

Graduate Nurses for medical services, evening & night shifts, $440 per mo. For details on California registration & on job opportunities, write: Betty Hartwig, R.N., Los Angeles County General Hospital, P.O. Box 1311; 1200 North State Street, Los Angeles 33, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital. Oakland 11, California.

Staff Nurse Positions open on all shifts for 50-bed modern Psychiatric Hospital located near colleges, universities & in the heart of a residential area. Salaries commensurate with experience. Personnel benefits include 2-wk. paid vacation, sick leave, paid Blue Cross. 8 paid holidays, & social security retirement. Apply: Miss Betty Remmel, R.N., The Westwood, 2112 S. Barrington Avenue, Los Angeles 25, California.

General Duty Nurses for 185-bed General Hospital in Boston area. Apply: Director of Nursing Service, St. John's Hospital, Lowell, Massachusetts.

COURSES FOR R.N.'S N.Y. POLYCLINIC MED. SCH. & HOSP. — in heart of Manhattan — 6-mo. courses in: O.R. NURSING OPD. NURSING. MED.-SURG. NURSING. Classes 4 times yrly: Mar., June, Sept., Dec. Room, meals, Medical Care & monthly cash stipend. Positions available to graduates of our Courses. For information write: Director of Nursing Education, 345 W. 50 St., N.Y.C., NEW YORK.

REGISTERED NURSES

MALE OR FEMALE

SEQUOIA HOSPITAL in Redwood City, California, U.S.A., has openings on its staff for Registered Nurses. Sequoia is a 350-bed district hospital which was opened in 1950.

Redwood City, with its population of 46,000, is located 25 miles south of San Francisco. Its slogan, "Climate Best by Government Test", is appropriate. This is a community of beautiful homes and gardens, fine schools and churches, and a hospital in which the residents take great pride.

Nurses must be eligible for registration in California.

SALARY: To start $371 per month with 5% increases at the 6, 12 and 24 month levels to a maximum of $429.
$15 differential for 3-11 shift. $10 differential for 11-7 shift.

VACATIONS: After 1 year —10 days (2 weeks)
After 2 years —15 days (3 weeks)
After 3 years —20 days (4 weeks)

SOCIAL SECURITY — GROUP INSURANCE — CREDIT UNION — PENSION PLAN (paid by the employer).

Affidavits guaranteeing employment will be furnished applicants when eligibility for California registration has been established.

For further information, write:

PERSONNEL OFFICE, SEQUOIA HOSPITAL,
REDWOOD CITY, CALIFORNIA, U.S.A.

HOTEL DIEU HOSPITAL

CORNWALL, ONTARIO

MODERN 300-BED HOSPITAL

requires

Clinical Instructor

in

MEDICINE, PEDIATRICS

and

OPERATING ROOM

also

General Staff Nurses

40 hour week — good salaries and personnel policies

APPLY:

DIRECTOR OF NURSING
HOTEL DIEU HOSPITAL
CORNWALL, ONTARIO

KINGSTON GENERAL HOSPITAL

has vacancies for

GENERAL STAFF NURSES IN Surgery and Medicine.

vacancies for

CLINICAL INSTRUCTORS
in Medicine and Psychiatry

For personnel policies and further information, apply to:

DIRECTOR OF NURSING,
KINGSTON GENERAL HOSPITAL,
KINGSTON, ONTARIO.

GRENFELL LABRADOR MEDICAL MISSION

Requires

NURSES FOR HOSPITALS IN LABRADOR AND NORTHERN NEWFOUNDLAND

For full information please write:

Miss Dorothy A. Plant, *Secretary*,
48 Sparks Street, Ottawa 4, Ontario.

THE PROVINCE OF MANITOBA requires a PUBLIC HEALTH NURSE V for the DEPARTMENT OF HEALTH & PUBLIC WELFARE

This is a senior administrative position in the central office of the Public Health Nursing Services. This officer is in charge of the practical nurses' training program for the province and acts as registrar and secretary under The Practical Nurses Act.

Applicants must be registered nurses, and hold a degree in nursing that includes a course in supervision, education, and administration, and have at least three years' experience in teaching and supervision in public health nursing.

SALARY RANGE: $4,800 - $6,000 per annum.

Full civil service benefits, including three weeks' annual vacation, liberal sick leave, pension and group insurance privileges.

Apply to: MANITOBA CIVIL SERVICE COMMISSION
Room 332 Legislative Building, Winnipeg 1, Manitoba.

GENERAL DUTY NURSES WANTED

Salary - $300 to $320 per month 40 hour week, no split shifts.

Vacation - 18 days plus 10 statutory holidays a year, 21 days sick leave cumulative from time of employment.

Transportation will be advanced if necessary.

Apply: Matron,

BERWYN MUNICIPAL HOSPITAL,
BERWYN, ALBERTA.

REGISTERED NURSES *and* CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities for all departments of new 140-bed hospital. Good personnel policies, O.H.A. Pension Plan.

Enquire:

DIRECTOR OF NURSING,
ROSS MEMORIAL HOSPITAL,
LINDSAY, ONTARIO.

Staff Nurses 380 bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds., & O.R., salaries $315 per mo. even., night or O.R. with call; 6-mo. increases up to $375; days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. or night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks, annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks. 5 yrs — 4 wks. Active inservice pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Staff Nurses: Exchange Visitor program offers opportunities to learn & earn at large modern tuberculosis hospital in convenient suburban Cleveland, Ohio. Start at $344 per mo. with semi-annual increments. 5-day work wk., paid vacation & 6 holidays, liberal sick leave, board, room & laundry at low rate in pleasant accommodations in nurses' home. Increase your professional experience at a progressive accredited hospital in an expanding community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $372. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

CLASSROOM AND CLINICAL INSTRUCTOR

required

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